

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00003

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL**DOA		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) First Edward Middle C. Athey Jr. Last Jr.		4. DATE OF DEATH Month January Day 13 Year 19 6D	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1958
9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward C. Athey		14. MOTHER'S MAIDEN NAME Dixie Lee Klosterman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Edward C. Athey Sr.		Address Creek Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis DUE TO Streptococcus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Streptococcus (c) Streptococcus			INTERVAL BETWEEN ONSET AND DEATH 1-2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 0 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 14, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF I-16-61	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE JAN 17 '61		24b. REGISTRAR'S SIGNATURE Carlton L. Kraus	

002 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00004

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Flintstone</u>		d. STREET ADDRESS <u>Route 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERT</u> Middle <u>EUGENE</u> Last <u>BENNETT</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1937</u>		9. AGE (In years last birthday) <u>23</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>M. P. Military Service (discharged Sept. 60)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chaneyville, Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Coyle Dayton Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Agnes Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1957-1960</u>		17. INFORMANT <u>Coyle Bennett, father, Flintstone, Rt. 2, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure; hydrothorax; ascites</u> DUE TO 570X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute glomerulonephritis</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>1-2 wks.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 1, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Brethren Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Flintstone, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Hofer</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

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VS. A15ME(5)
SM 9/55

003

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

00005

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle R. Last BISHOP				4. DATE OF DEATH Month JANUARY Day 12 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1884		9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truckman		10b. KIND OF BUSINESS OR INDUSTRY B+O Railroad		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NATHAN BISHOP				14. MOTHER'S MAIDEN NAME HESTER ANN ASBURY ASKEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Paralytic Stroke DUE TO Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 wks 2 wks 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10 1961 to Jan 12 1961 , that (I) (we) last saw the deceased alive on Jan 12 1961 , and that death occurred at 2:35 PM from the causes and on the date stated above.							
22a. SIGNATURE Clay E. Durrett				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT				22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		Jan 15, 1961		Oliver Grove Meth. Cem.		Near Oldtown Md	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Hafer				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

002

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

004

CERTIFICATE OF DEATH

00006

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND c. LENGTH OF STAY IN TB 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND d. STREET ADDRESS ROUTE #4, BOX 310							
3. NAME OF DECEASED (Type or print) LYNN ABNER BISHOP				4. DATE OF DEATH Month JANUARY Day 1 Year 1961							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-1911		9. AGE (In years last birthday) 49 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.: Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trucker (C.A) Dept				10b. KIND OF BUSINESS OR INDUSTRY Textile Mill		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA, Oldtown		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ABNER BISHOP				14. MOTHER'S MAIDEN NAME EDITH ARNOLD							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-10-7577		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arterio-sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown								INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to Jan 1, 1961 , that (I) (we) last saw the deceased alive on Jan 1, 1961 , and that death occurred at 12:25 PM from the causes and on the date stated above.											
22a. SIGNATURE L. Michael Glick M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12-29							
22c. PHYSICIAN'S NAME (Type) L. Michael Glick				22d. ADDRESS 126 N. Smallwood Street, Cumberland, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-4-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cem.		23d. LOCATION (City, town or county) (State) Cumberland, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 4 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
005 CERTIFICATE OF DEATH

00007

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 1/11/61		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 434 Williams Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jennie Middle M. Last Brown				4. DATE OF DEATH Month January Day 20, Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/15/1871	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Daniel Stuart				14. MOTHER'S MAIDEN NAME Jane Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertosis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Degeneration DUE TO (c) Cerebral arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH 48 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Dehydration.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/11/61 19 to 1/20/61 19, that (I) (we) last saw the deceased alive on 1/19/61 19, and that death occurred at 11:45 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE James E. McLean M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/20/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland Maryland				25a. REC'D BY REGISTRAR JAN 24 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

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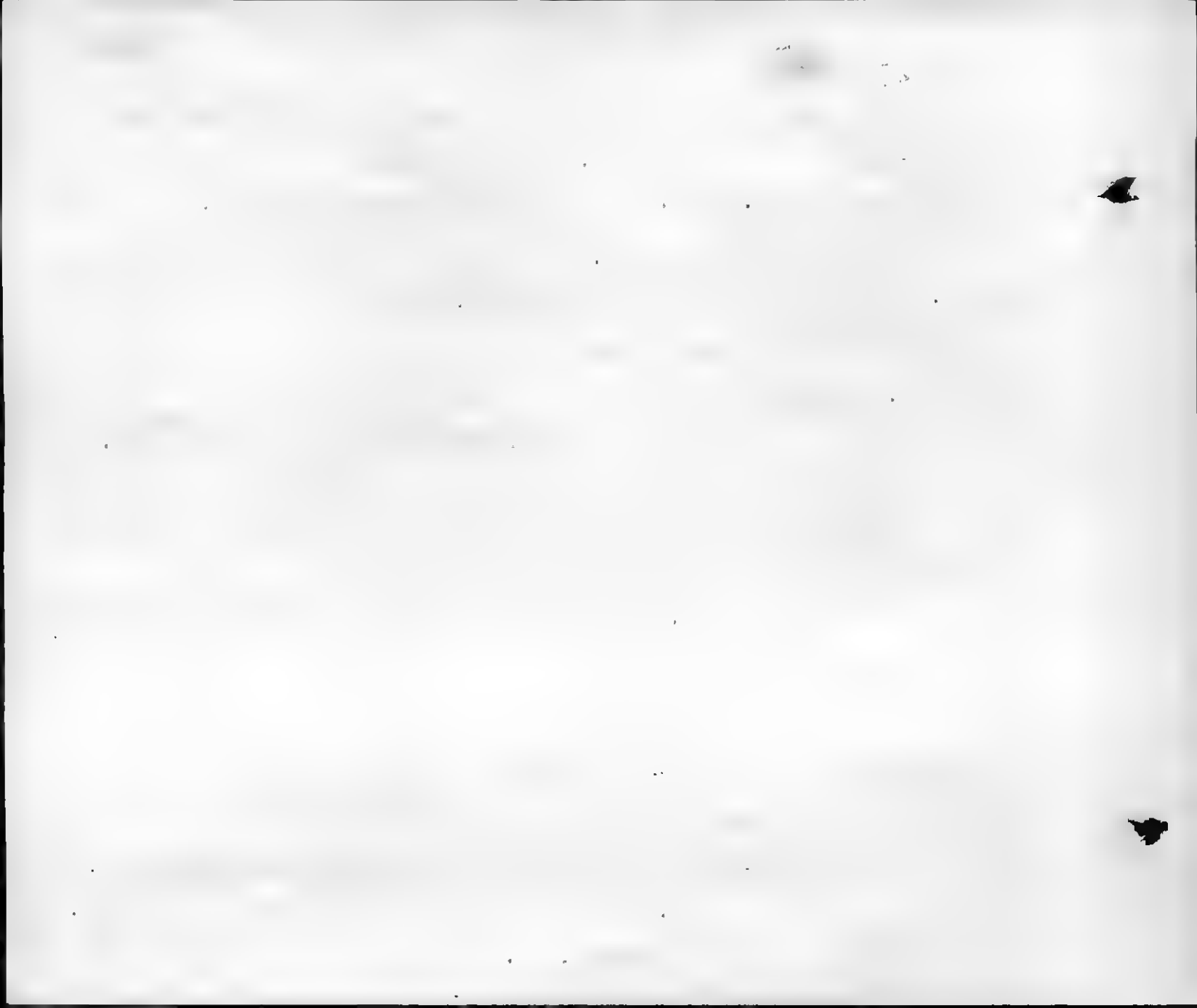
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
006 **CERTIFICATE OF DEATH**

00008

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. LENGTH OF STAY IN 1b 17 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 Centennial St. Extd.				d. STREET ADDRESS 119 Centennial St. Extd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Byrnes				4. DATE OF DEATH Month January Day 4th , Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1st, 1878	
9. AGE (In years last birthday) 82 yrs		10. UNDER 1 YEAR Months 82 Days 0 Hours 0 Min. 0		11. UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Grimes				14. MOTHER'S MAIDEN NAME Margaret Shea			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna Robinson, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic Cordia- DUE TO Vascular disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 42 years DUE TO (c) 4 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Serious							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19			
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20e. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-1 to 1-4 , 19 61 , that (I) (we) last saw the deceased alive on 1-4 , 19 61 , and that death occurred at 11 P.M. from the causes and on the date stated above							
22a. SIGNATURE H. C. Diehl,				22b. DATE SIGNED 1/6/61			
22c. PHYSICIAN'S NAME (Type) H. C. Diehl,				22d. ADDRESS 39 W. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-7-61		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Burst				25a. REC'D BY REGISTRAR 9 '61			
ADDRESS Frostburg, Md.				25b. REGISTRAR'S SIGNATURE W. J. H. H. H.			



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

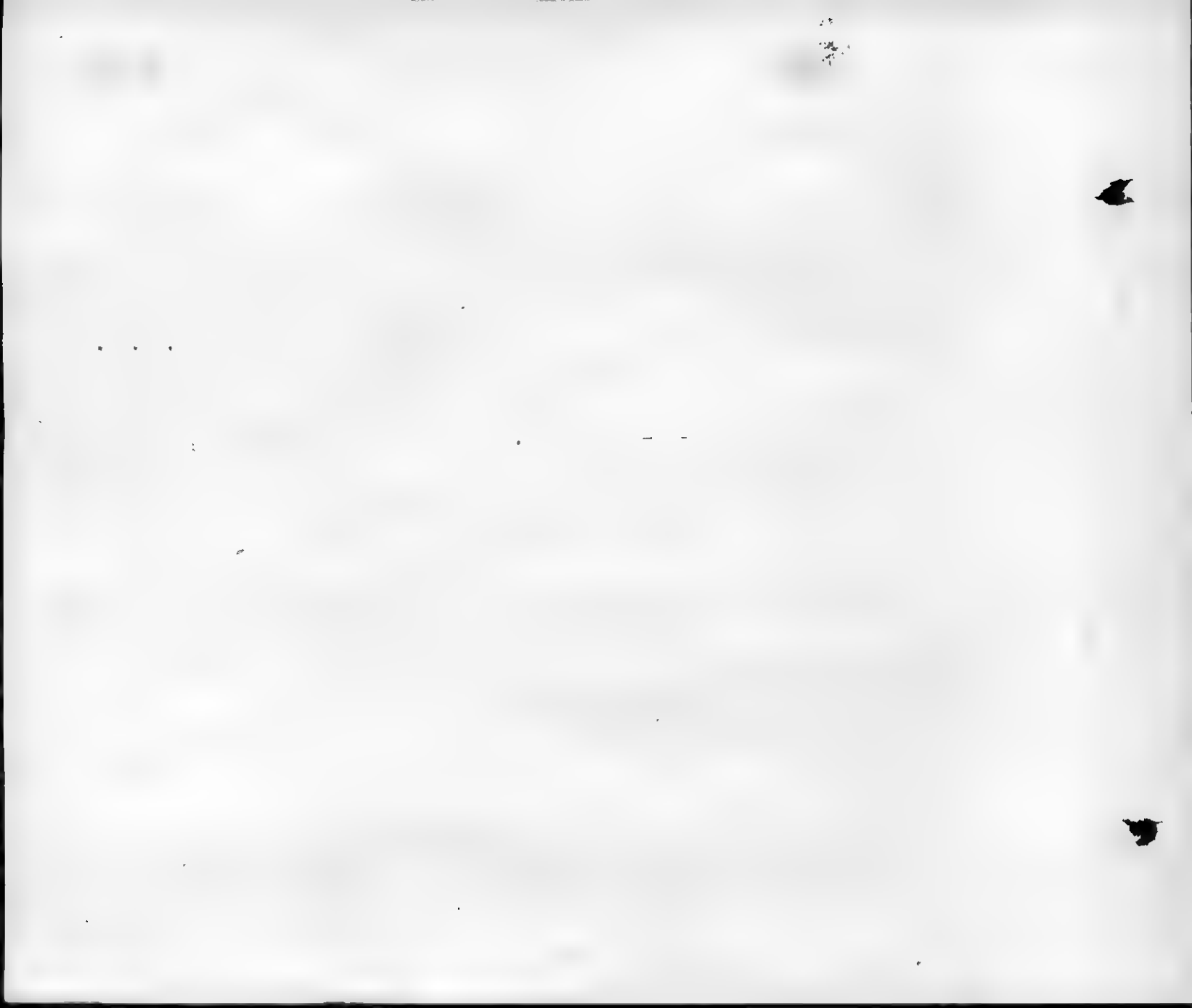
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

007

CERTIFICATE OF DEATH

00009

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 506 Decatur Street				d. STREET ADDRESS 506 Decatur Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elwood Middle John Last Cannon				4. DATE OF DEATH Month January Day 28 Year 19 61			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Nov 13, 1908	
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months 52 Days 52 Hours 52 Min 52		IF UNDER 24 HRS. Months 52 Days 52 Hours 52 Min 52			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Army service		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Otto Cannon				14. MOTHER'S MAIDEN NAME Blanche Lease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes W W II				16. SOCIAL SECURITY NO 214-26-8068		17. INFORMANT Mrs. Richard Lowman	
Route Address #3 Hazen Road,				Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1/28 19 61 , to 1/28 19 61 , that (I) (we) last saw the deceased alive on 1/28 19 61 , and that death occurred at 9 AM , from the causes and on the date stated above							
22a. SIGNATURE Leo H. Ley Jr.				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/30/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.				22d. ADDRESS 452 N. Centre St. Cumberland, Ind.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington		23d. LOCATION (City, town, or county) (State) Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR FEB 1 '61	
				25b. REGISTRAR'S SIGNATURE Caroline S. Hanna			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

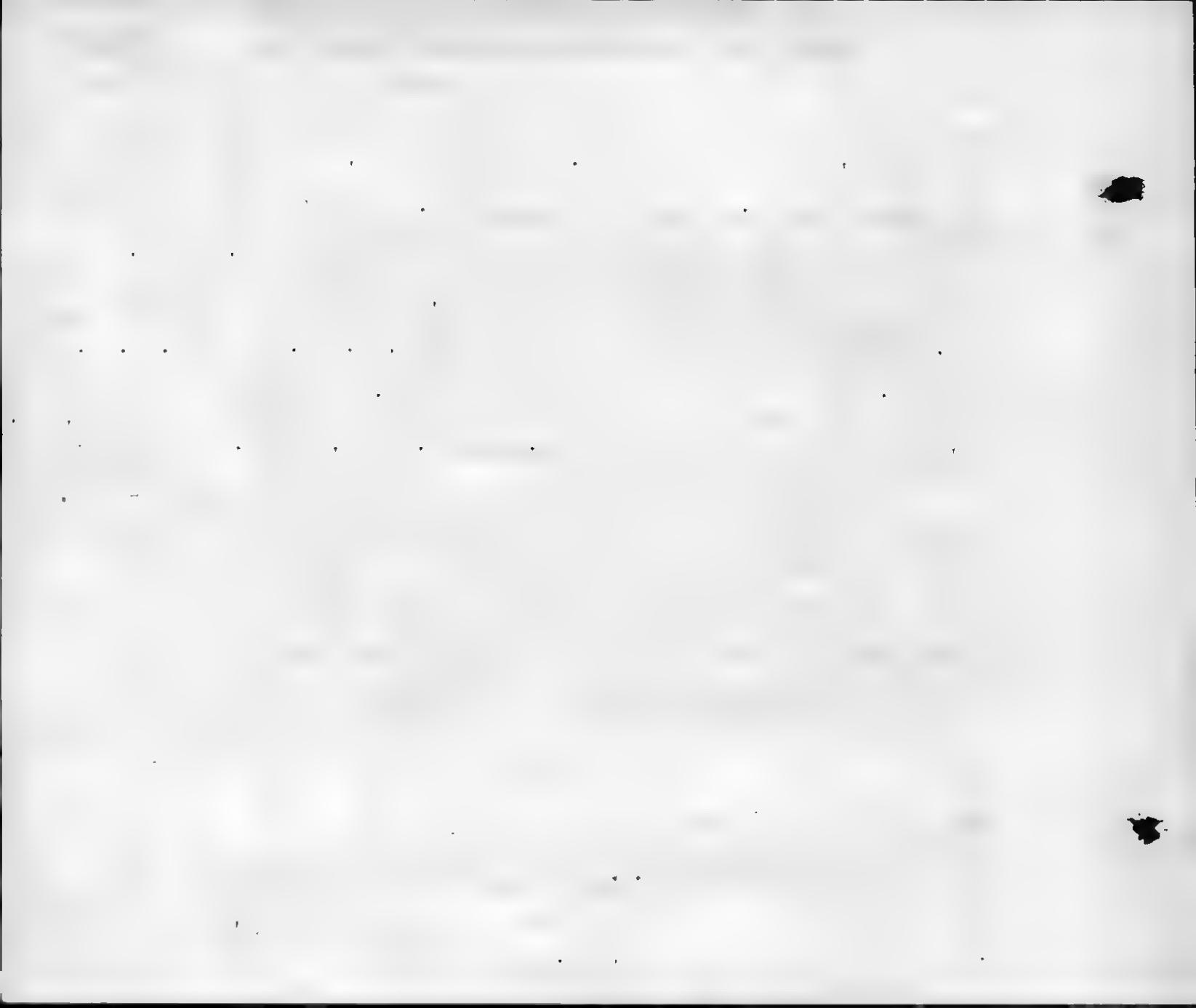
008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 17 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hosp.				d. STREET ADDRESS 304 N. Waverly Terrace			
3. NAME OF DECEASED (Type or print) First GILBERT Middle WILLIAM Last COLE				4. DATE OF DEATH Month Jan. Day 17, Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH June 26, 1907		9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. & Owner		10b. KIND OF BUSINESS OR INDUSTRY Meat Market		11. BIRTHPLACE (State or foreign country) Bolivar, W. Va.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME John W. Cole			
14. MOTHER'S MAIDEN NAME Alice A. McCormick				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 214-05-5208				17. INFORMANT Address Cumberland, Md. Mrs. Ruth E. Cole, 304 N. Waverly Terrace			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC TAMPONADE DUE TO 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RUPTURED DISSECTING ANEURYSM OF AORTA DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 3-4 Hrs. 24 Hrs (?)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED JANUARY 17, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/61		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park			
22d. LOCATION (City, town, or county) Cumberland,		(State) Maryland		24a. REC'D BY REGISTRAR JAN 23 '61			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				24b. REGISTRAR'S SIGNATURE <i>W. L. S. Smith</i>			
ADDRESS Cumberland, Md.							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
009					00011				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
a. COUNTY Allegany					a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,					b. COUNTY Allegany				
c. LENGTH OF STAY IN 1b 64yrs					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 308 Pennsylvania Ave					d. STREET ADDRESS 308 Pennsylvania Ave				
3. NAME OF DECEASED (Type or print) Emma Lena Collins					4. DATE OF DEATH Jan. 17, 1961				
5. SEX F					6. COLOR OR RACE W				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH Dec. 27, 1882					9. AGE (In years last birthday) 78 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Ownhome				
11. BIRTHPLACE (County & State, or foreign country) Artemas, Pa.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Jacob Potts					14. MOTHER'S MAIDEN NAME Arthelia Goodrich				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO None				
17. INFORMANT Richard J. Collins					Address 308 Pa. Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Vascular Disease									
260X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Advanced									
DUE TO (c) Diabetes Mellitus									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year 1-16-61									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1-17-61									
20f. (City or town) Cumberland, Md.									
(County) Cumberland, Md.									
(State) Md.									
21. I certify that (I) (this hospital) attended the deceased from 1-16-61 to 1-17-61 that (I) (we) last saw the deceased alive on 1-16-61 , and that death occurred at 2:15P from the causes and on the date stated above.									
22a. SIGNATURE W.F. Williams M.D.									
22b. DATE SIGNED 1-18-61									
22c. PHYSICIAN'S NAME (Type) W.F. Williams									
22d. ADDRESS 122 S Centre St. Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF I-20-61									
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.									
23d. LOCATION (City, town or county) Cumberland, Md.									
(State) Md.									
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli									
ADDRESS Cumberland, Md.									
25a. REC'D BY REGISTRAR DATE JAN 24 '61									
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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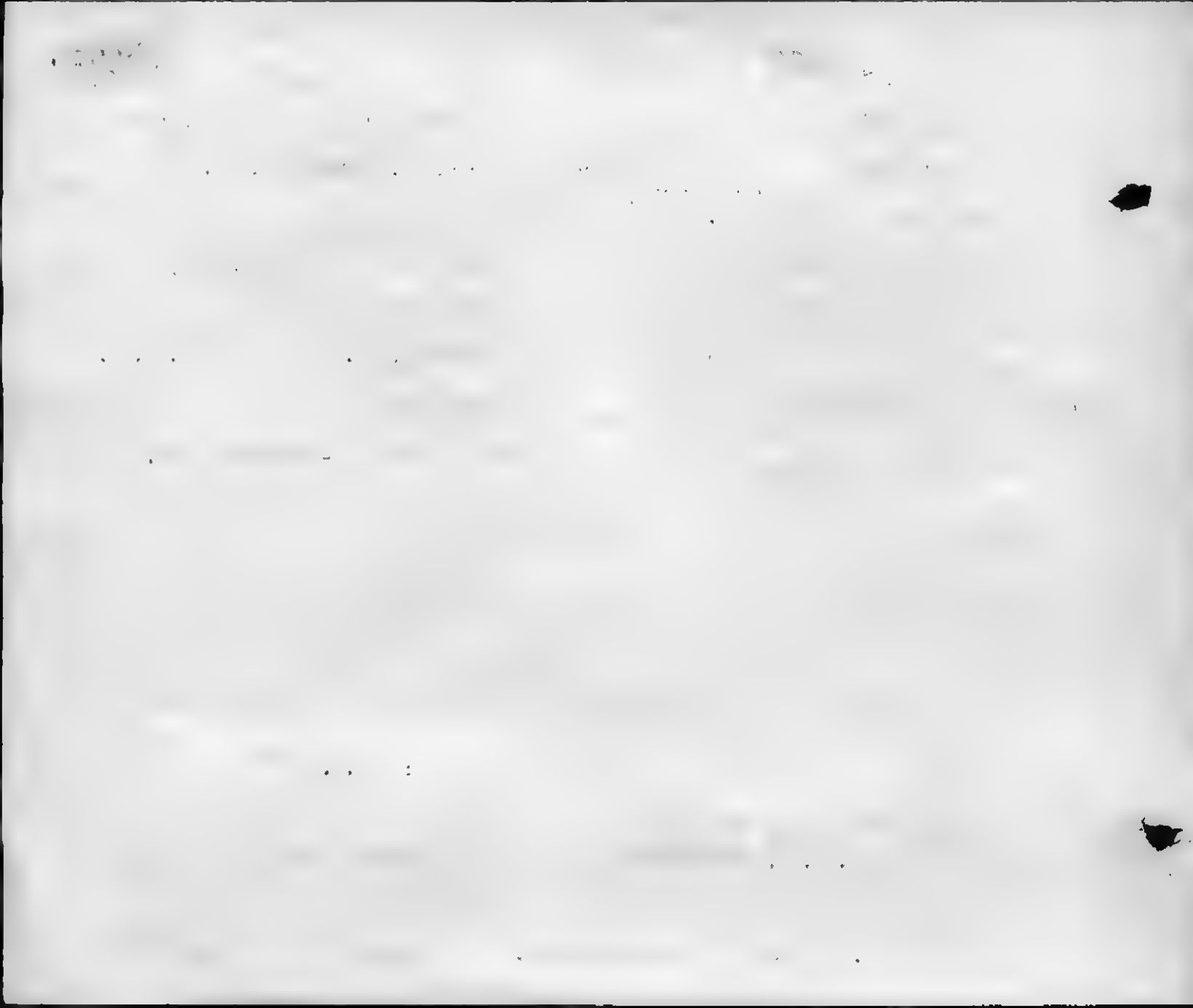
CERTIFICATE OF DEATH

05005

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 13 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE #4, CUMBERLAND, MD. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RONALD ROY COOK		4. DATE OF DEATH JANUARY 31, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1947
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Grade school	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
13. FATHER'S NAME CLYDE DAYTON COOK		14. MOTHER'S MAIDEN NAME FRANCES GROVE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 173.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Corebellar Tumor - Cancer DUE TO (c) 173.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Malignant Hypertension		12. CITIZEN OF WHAT COUNTRY? U. S. A. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 14 months	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter name of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 31, 1961 to Jan 31, 1961 , that (I) (we) last saw the deceased alive on Jan 31, 1961 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 2/2/61	
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT		22d. ADDRESS 133 VIRGINIA AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-61	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpetti		25a. REC'D BY REGISTRAR FEB 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



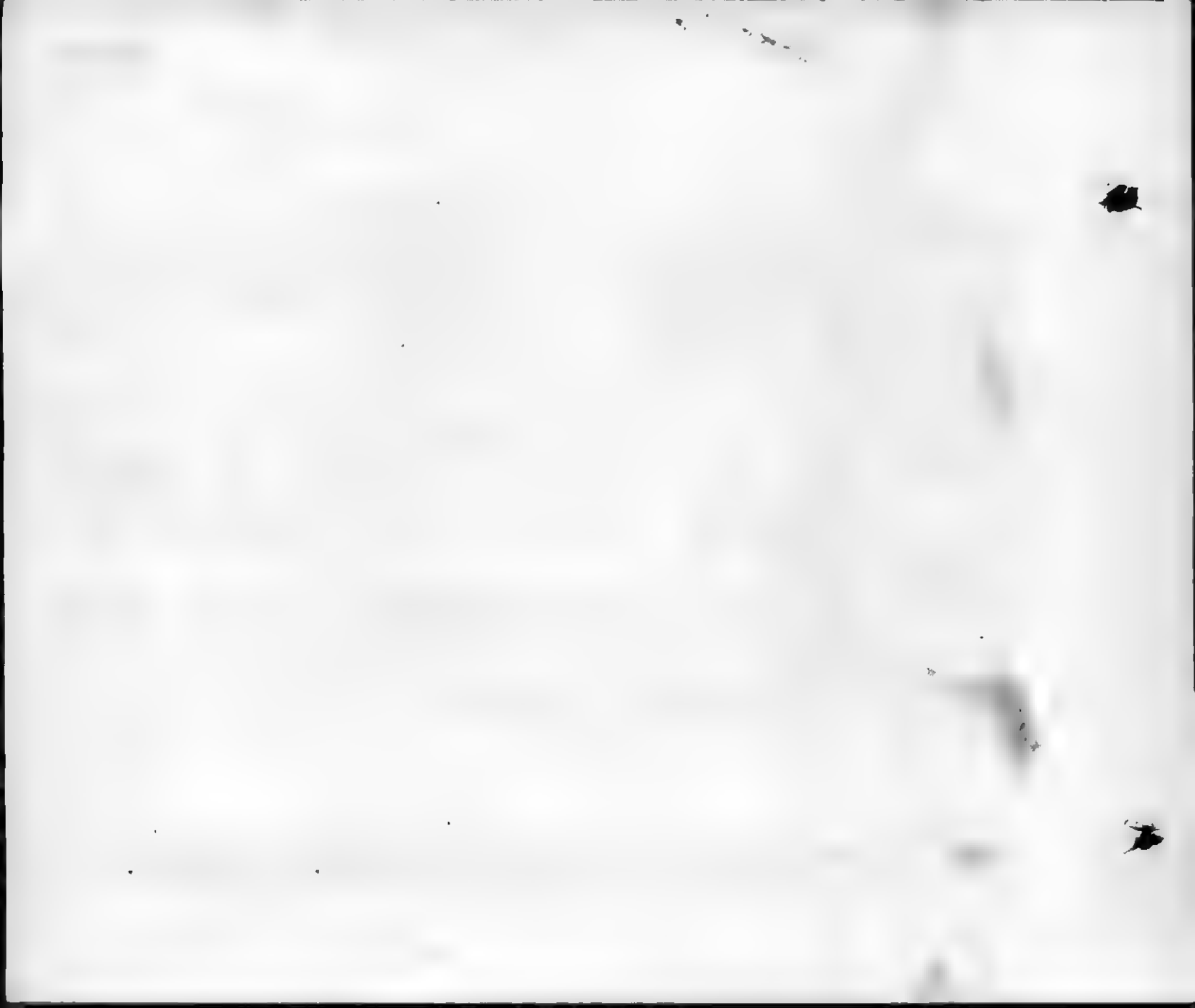
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

011 **CERTIFICATE OF DEATH** 00012

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND				c. LENGTH OF STAY IN 1b 23 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. STREET ADDRESS 624 N. CENTRE STREET			
3. NAME OF DECEASED (Type or print) First ELLA Middle MAE Last COUGHENOUR				4. DATE OF DEATH Month 1 Day 15 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/85	
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months 1 Days 15		IF UNDER 24 HRS. Hours 19 Min 61		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? UNITED STATE			
13. FATHER'S NAME Albert Glesner				14. MOTHER'S MAIDEN NAME DELLA GLESNER HEMB (D)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Lee Moyer Cumberland, Md. CHAPT			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary heart disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Urinary infection, pyelonephritis, osteoarthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 to 1/15 1961 that (I) (we) last saw the deceased alive on 1/14 1961 and that death occurred at 8:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Elizabeth Briggs				22b. DATE SIGNED 1/15/61		22c. PHYSICIAN'S NAME (Type) DR. E. BRINGS	
22d. ADDRESS 55 Green St. Cumberland, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				25a. REC'D BY REGISTRAR DATE JAN 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

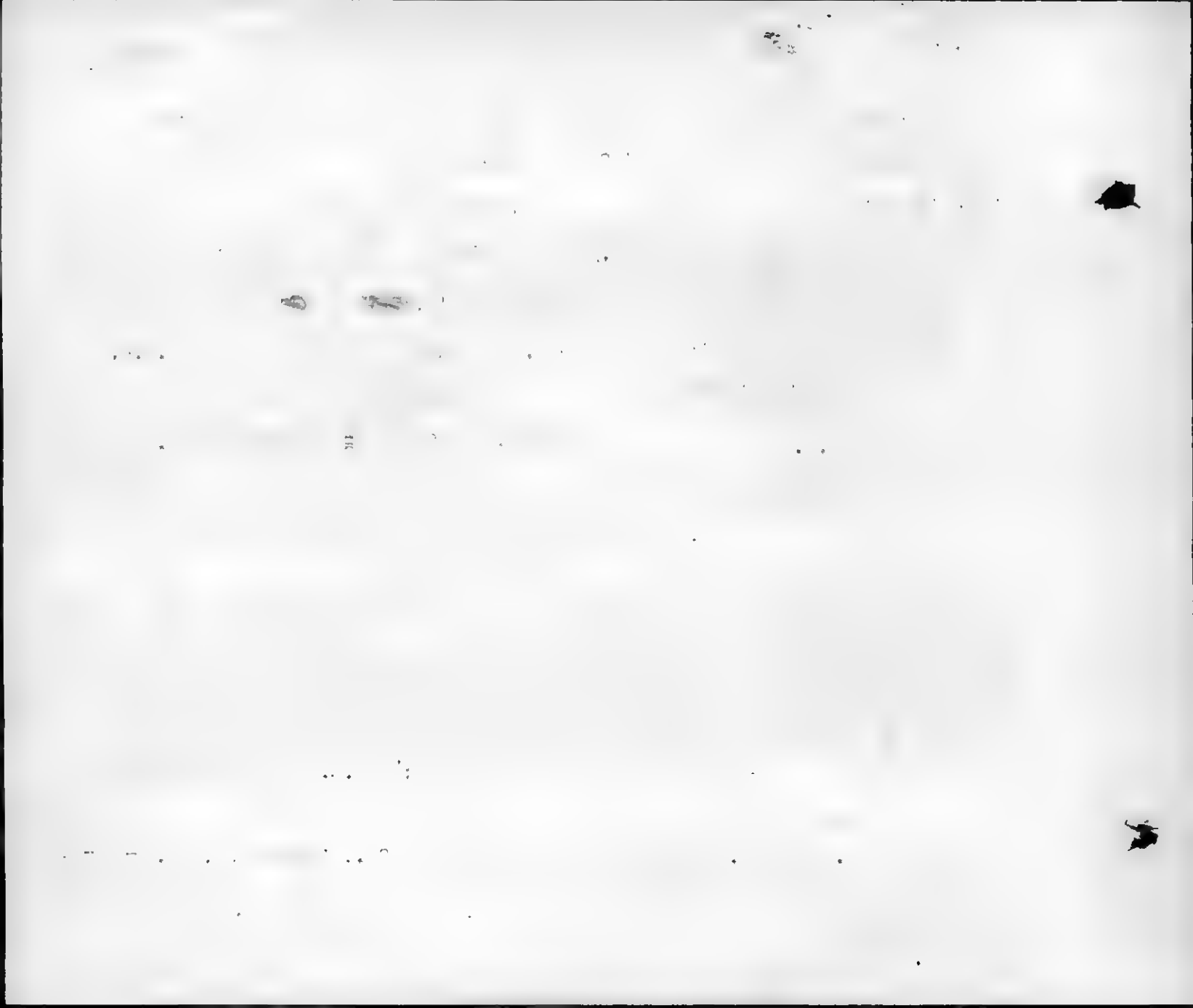
DR. BALLIN

012

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00013

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 633 HILL TOP DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle Paul Last CRABTREE				4. DATE OF DEATH Month JANUARY Day 17 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1892 OCTOBER 14, 1892		9. AGE (In years last birthday) 68 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Police Officer		10b. KIND OF BUSINESS OR INDUSTRY City Police Dept.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEONARD CRABTREE				14. MOTHER'S MAIDEN NAME FANNIE OGDON MEYERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1		17. INFORMANT MEMORIAL HOSPITAL & CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident 42 DUE TO (b) arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 13 19 55 to 1 - 17 19 61 , that (I) (we) last saw the deceased alive on 1 - 16 19 61 , and that death occurred at 2:47 A.M. the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin				22b. DATE SIGNED 1-17-61		22c. PHYSICIAN'S NAME (Type) DR. RALPH W. BALLIN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR JAN 23 '61		25b. REGISTRAR'S SIGNATURE John J. Hafer	

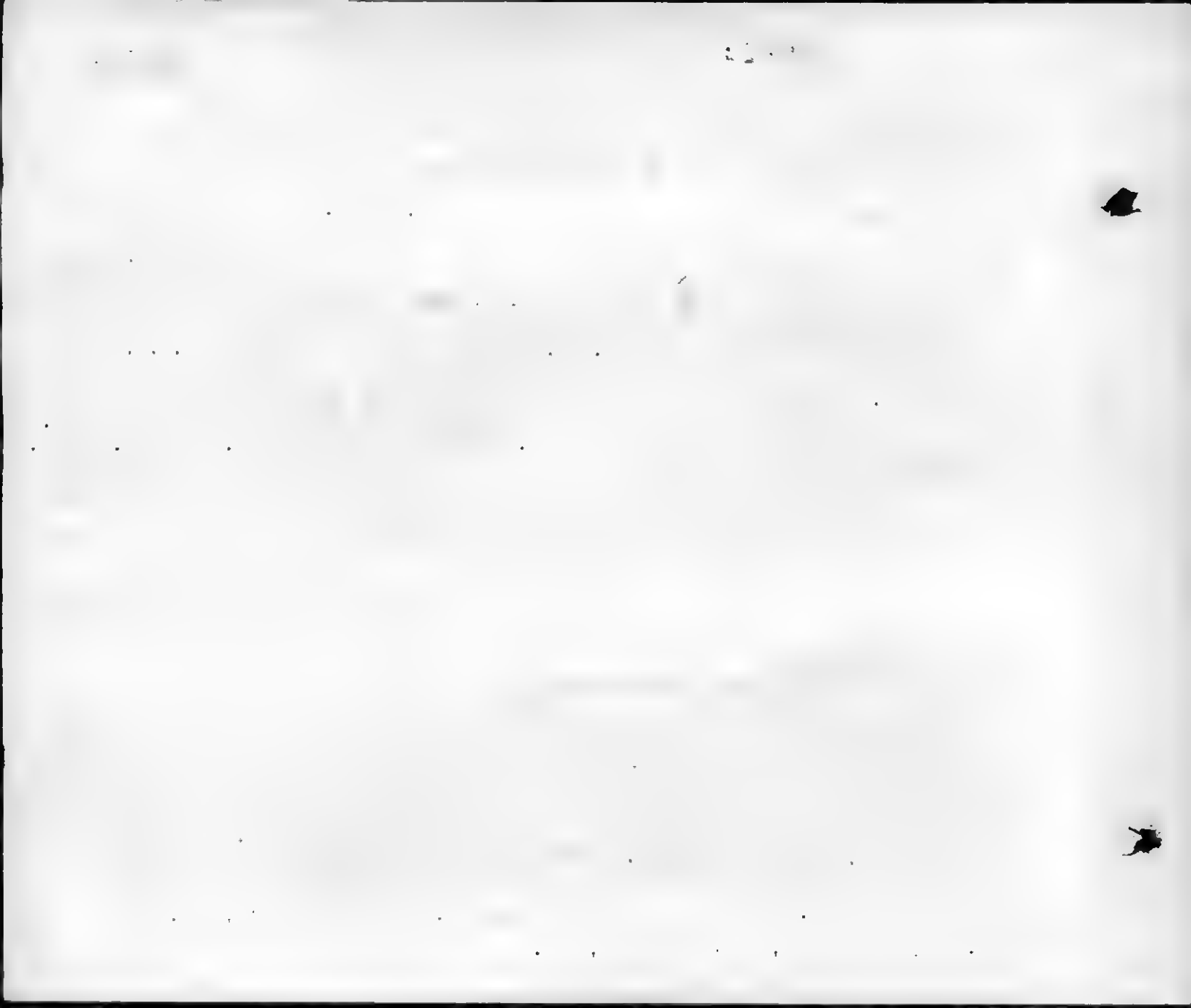


1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

013
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

62014

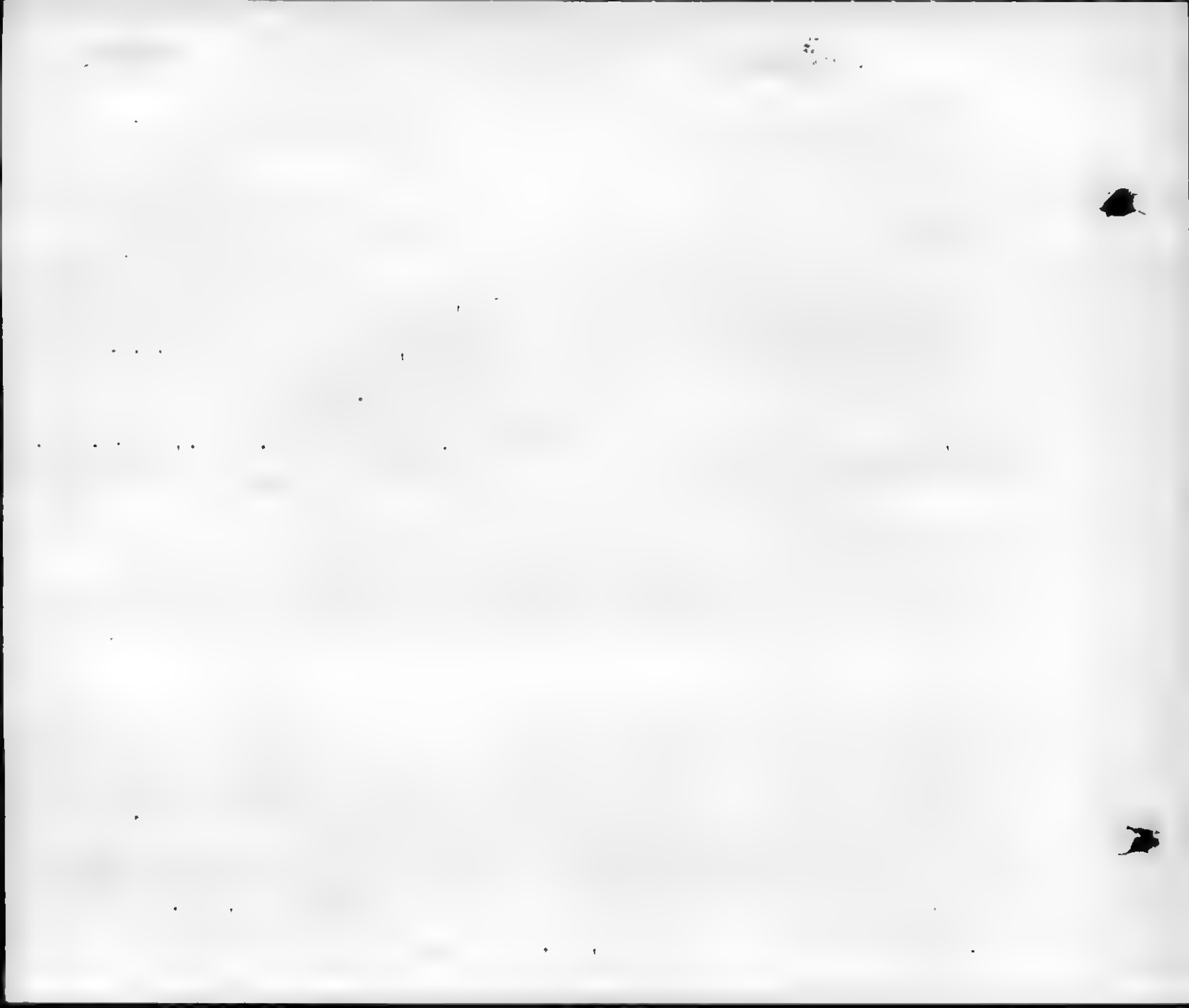
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ERNEST Last CRAMER				4. DATE OF DEATH Month JANUARY Day 6 Year 1961			
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-15-1898	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY Western Md. RR.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM F. CRAMER				14. MOTHER'S MAIDEN NAME CLARA BENNER CRAMER			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Md. Mrs. James Cramer 212 S. Lee St. Cumb.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident						INTERVAL BETWEEN ONSET AND DEATH 16 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardio-vascular disease						4 years	
DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid Arthritis							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 1 - 20 - 1957 to 1 - 6 - 1961 , that (I) (we) last saw the deceased alive on 1 - 5 - 1961 and that death occurred at 5 AM , from the causes and on the date stated above.							
22a SIGNATURE Ralph B. Ballin M.D.				22b DATE SIGNED 1-6-61			
22c PHYSICIAN'S NAME (Type) DR. RALPH BALLIN, M.D.				22d. ADDRESS 62 Greene St. Cumberland, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Jan. 8 1961		23c NAME OF CEMETERY OR CREMATORY Mountain View Cem.		23d LOCATION (City, town, or county) (State) Sharpsburg, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Wayne George, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 9 '61		25b REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
014 **CERTIFICATE OF DEATH**

00015

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C2 CUMBERLAND			
c. LENGTH OF STAY IN 1b 3 days				d. STREET ADDRESS 1 16 WILLISON PLACE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle FLOYD Last DAVIS				4. DATE OF DEATH Month JANUARY Day 7 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1900	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0		IF UNDER 24 HRS: Months 0 Days 0 Hours 0 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Brakeman				10b. KIND OF BUSINESS OR INDUSTRY B & O RAILROAD		11. BIRTHPLACE (State or foreign country) Oldtown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES DAVIS				14. MOTHER'S MAIDEN NAME Nellie V. Twigg			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Richard H. Davis 22 Va. Ave., Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 502.0 DUE TO (b) Pulmonary Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) Bronchitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							
INTERVAL BETWEEN ONSET AND DEATH 4 days unknown unknown							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 Jan 1961 to 7 Jan 1961 , that (I) (we) last saw the deceased alive on 7 Jan 1961 , and that death occurred at 11:30 P.M., from the causes and on the date stated above							
22a. SIGNATURE L. Michael Glick M.D.				22b. DATE SIGNED 1/8/61		22c. PHYSICIAN'S NAME (Type) L MICHAEL GLICK	
22d. ADDRESS 124 N. SMALLWOOD ST. CUMBERLAND MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/10/61		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 10 '61	
25b. REGISTRAR'S SIGNATURE Robert S. Frank							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

015

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00016

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 11 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.				d. STREET ADDRESS 145 BEDFORD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GARNET Middle W. Last DAVIS				4. DATE OF DEATH Month JANUARY Day 12 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 5, 1906	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min 55		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President				10b. KIND OF BUSINESS OR INDUSTRY Neon Sign Company		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME THOMAS DAVIS				14. MOTHER'S MAIDEN NAME NORA WILSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214 05 5670		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pharyngeal Cancerous Heart Failure 4-50-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) Generalized Atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 wks. 1-2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pericardial effusion							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7, 1960 to Jan 12, 1961 , that (I) (we) last saw the deceased alive on 1-12 1961, and that death occurred at 7:41 P.M. from the causes and on the date stated above.							
22a. SIGNATURE William P. James				22b. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.		22c. PHYSICIAN'S NAME (Type) DR. W. P. JAMES	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				25a. REC'D BY REGISTRAR DATE JAN 17 '61		25b. REGISTRAR'S SIGNATURE W. P. James	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

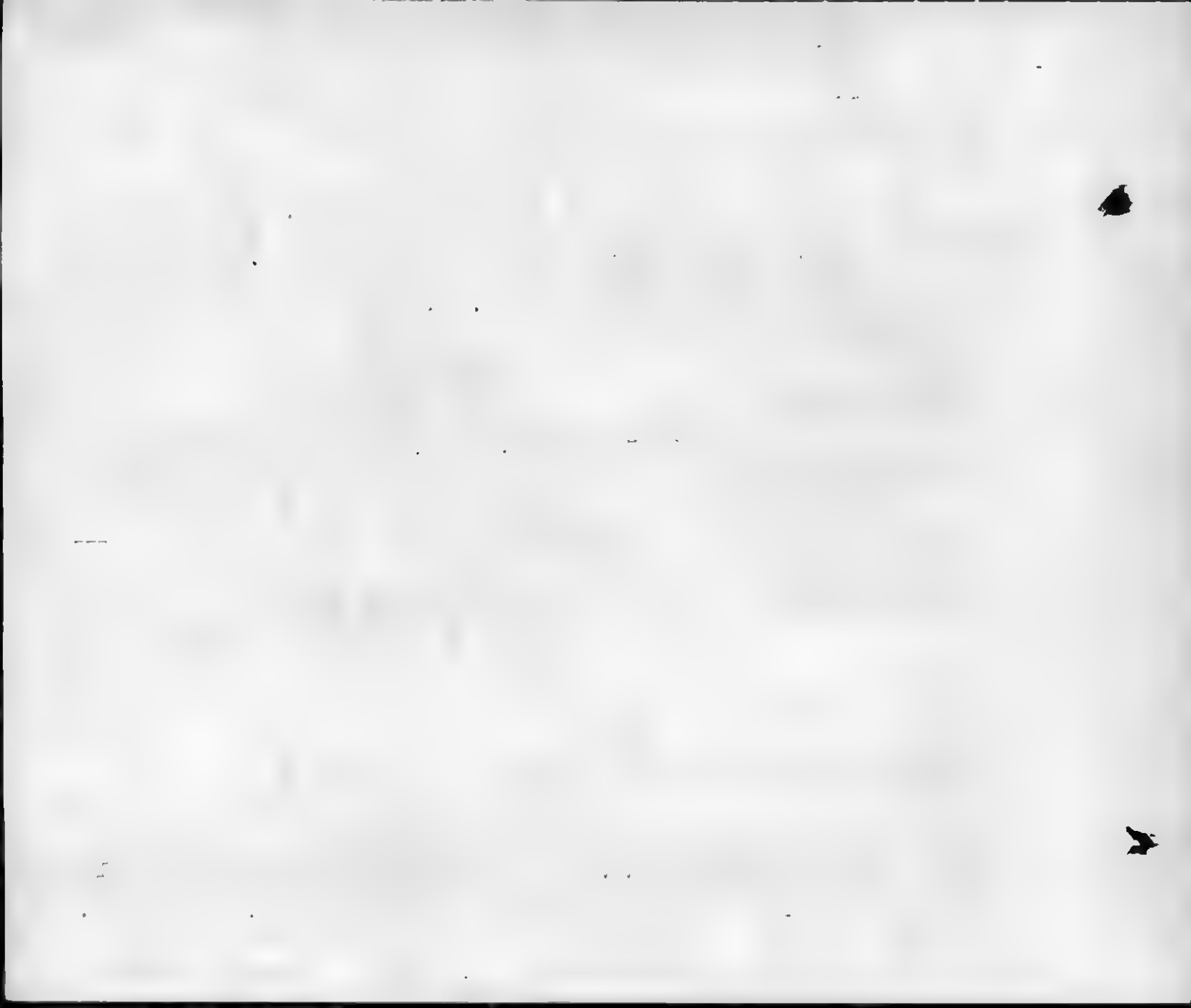
00017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>1 hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg,</u> d. STREET ADDRESS <u>192 West Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Bernard</u> Last <u>Davis</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1961</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <u>Sept. 5, 1900</u>							
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hosteler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Race track</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>							
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry Quaster</u>							
14. MOTHER'S MAIDEN NAME <u>Jennie Skelton</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>211-05-8298</u>							
17. INFORMANT <u>Mrs. Minnie Grant, Frostburg, Md.</u>				Address <u>192 W. Main Street</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="width: 70%;"> CORONARY OCCLUSION CORONARY SCLEROSIS </td> <td style="width: 10%;"> INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> </td> </tr> <tr> <td colspan="3"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	CORONARY OCCLUSION CORONARY SCLEROSIS	INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	CORONARY OCCLUSION CORONARY SCLEROSIS	INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skelton</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <u>BENEDICT SKELTON, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>JANUARY 13, 1961</u>				DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>							
22d. LOCATION (City, town, or county) <u>Frostburg,</u>		(State) <u>Md.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Dewart</u>			ADDRESS <u>Frostburg, Md.</u>								
24a. REC'D BY REGISTRAR <u>MAN 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Thoma</u>									

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 58 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 Grand Ave.				d. STREET ADDRESS 211 Grand Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle F. Last Deering				4. DATE OF DEATH Month Jan. Day 2 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1884	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days 		11. IF UNDER 24 HRS. Hours Min. 		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Buckvalley, Pa.	
13. FATHER'S NAME William P. Lashley				14. MOTHER'S MAIDEN NAME Harriett Northcraft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 		17. INFORMANT Address Miss Olive Deering, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4-20-1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) *-- DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Jan. 2, 1961			
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 1-5-1961		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR JAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kawa	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

018

00019

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MINERS HOSPITAL				e. STREET ADDRESS 18 1/2 CENTENNIAL ST.			
3. NAME OF DECEASED (Type or print) First GRANT Middle U. Last DEIBLER				4. DATE OF DEATH Month JANUARY Day 27 , Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1874	9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER			10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME OBED DEIBLER				14. MOTHER'S MAIDEN NAME LYDIA BOWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service.)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. FRANCIS CUNNINGHAM, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric carcinoma 571.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) X					
20c. TIME OF INJURY Month, Day, Year Hour a. m. X 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X	20f. (City or town) X	(County)		(State)	
21. I certify that (I) (the hospital) attended the deceased from 1/27/61 to JAN 27, 1961 , that (I) (we) last saw the deceased alive on 1/27 19 61 , and that death occurred at 11:27 M, from the causes and on the date stated above.							
22a. SIGNATURE Martin Rothstein		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE, SIGNED 1/27/61		
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.		22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-30-1961	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durost		ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE JAN 30 '61	25b. REGISTRAR'S SIGNATURE C. T. H. H.		

M

061

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pays may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

019

CERTIFICATE OF DEATH

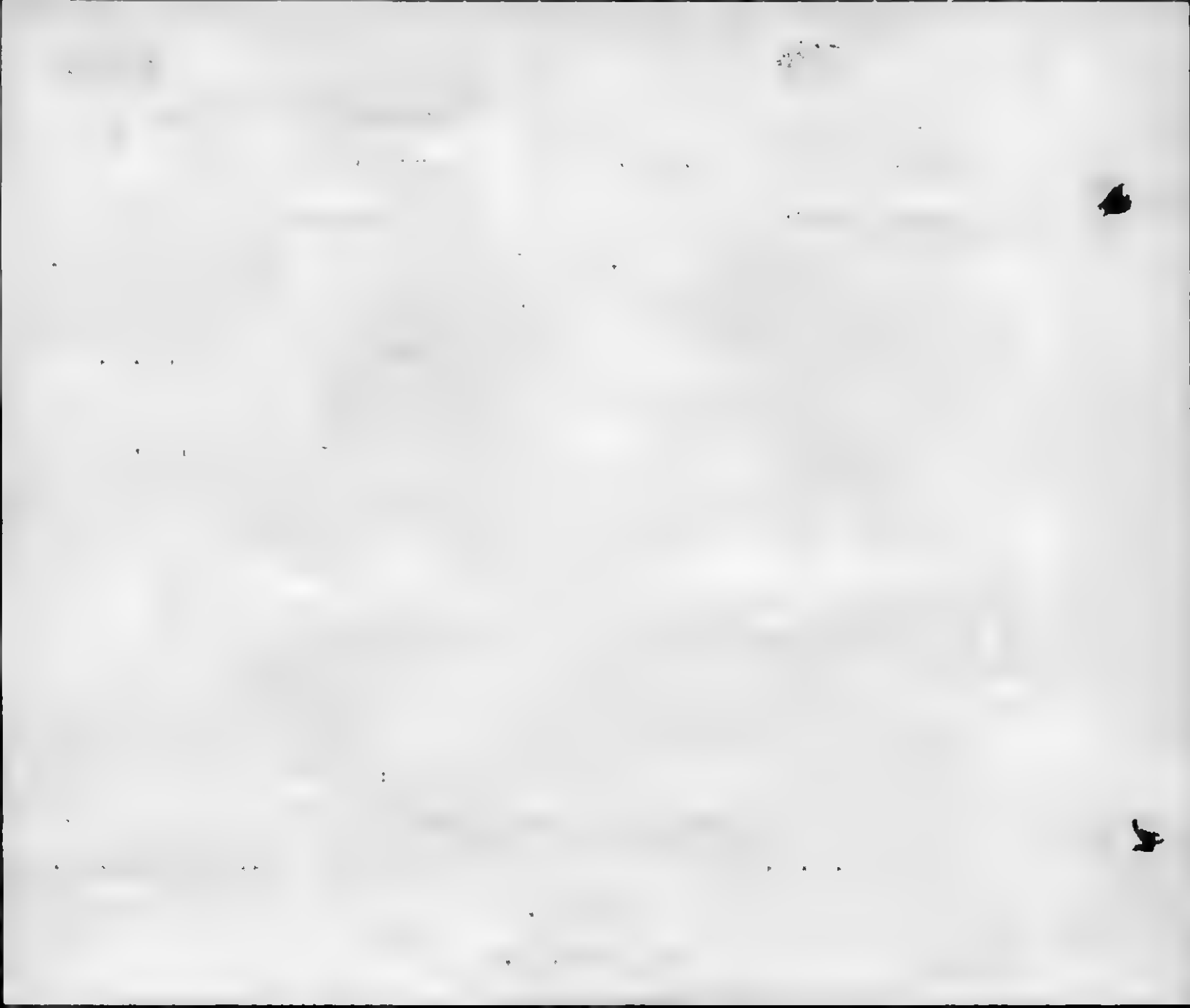
Item 7, Film G-265 4-7701.cuc.

00022

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 30 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		d. STREET ADDRESS 7426 TAYLOR STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM P. DE WITT		4. DATE OF DEATH JANUARY 27, 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APRIL 10, 1897		9. AGE (In years last birthday) 63 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME GEORGE DE WITT		14. MOTHER'S MAIDEN NAME MARGARET MACKIE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Perforated diverticulitis, colon DUE TO (b) Left lower lobe pneumonia DUE TO (c) Gastric Resection for Penetr. ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). Arteriosclerosis & nephrosclerosis		INTERVAL BETWEEN ONSET AND DEATH 7-8 days 9-10 days 16 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 19..... to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at 12:30 PM from the causes and on the date stated above.																			
22a. SIGNATURE <i>A. J. Mirkin</i>		22b. DATE SIGNED 1-28-61		22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22d. ADDRESS 115 SOUTH CENTRE ST., CUMBERLAND, MD.		22e. REC'D BY REGISTRAR DATE FEB 2 '61		22f. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/30/61		23c. NAME OF CEMETERY OR CREMATORY Philos Cem.		23d. LOCATION (City, town or county) (State) Westernport, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. S. Ford</i> ADDRESS Westernport, Md.																			

MEDICAL CERTIFICATION

I



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00020**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 14 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LLOYD Middle THURMAN Last DRAKE				4. DATE OF DEATH Month January Day 3, Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 26, 1915	
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Line				10b. KIND OF BUSINESS OR INDUSTRY G.L. Martin Aircraft		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Isaac Drake				14. MOTHER'S MAIDEN NAME Esther Dolan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-14-6891		17. INFORMANT Franklin Drake, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EDEMA;; CARDIAC FAILURE DUE TO (b) COR TRUNC PULMONALE DUE TO (c) EMPHYSEMA, BRONCHIECTASIS INTERVAL BETWEEN ONSET AND DEATH 2-3 Days 1-2 Yrs. 1 Yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/5/61		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) Cumberland, Maryland				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR JAN 6 '61		24b. REGISTRAR'S SIGNATURE C. W. S. K. K.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



021

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

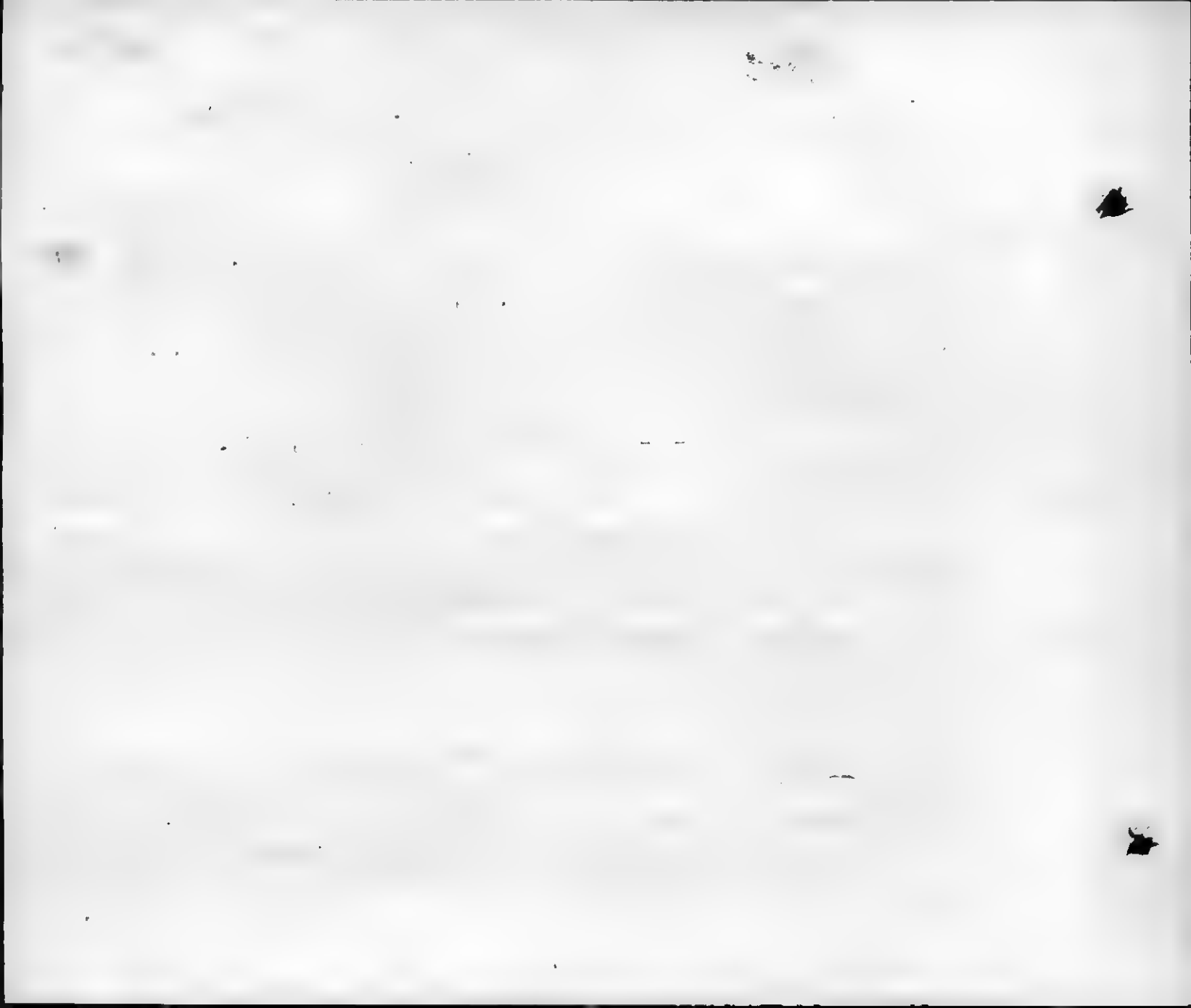
CERTIFICATE OF DEATH

00021

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. LENGTH OF STAY IN 1b 69 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 Popular				d. STREET ADDRESS 218 Popular			
3. NAME OF DECEASED (Type or print) First Francis Middle Fazenbaker Last Fazenbaker				4. DATE OF DEATH Month Jan. Day 10 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 21, 1891	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY City of Westernport Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A./							
13. FATHER'S NAME Augustus Fazenbaker				14. MOTHER'S MAIDEN NAME Ida Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 705-10-7026		17. INFORMANT Howard Fazenbaker-Dover, Ohio.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral Hemorrhage							
DUE TO (b) Hypertension							
DUE TO (c) 5 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found Dead in Home by Neighbor							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 Jan 10 1961							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 10 1961 to Jan 12 1961 , that (I) (we) last saw the deceased on Jan 10 1961 and that death occurred at 4P M. from the causes and on the date stated above.							
22a. SIGNATURE Paul R. Wilson M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE Jan. 12, 1961							
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D. 22d. ADDRESS Piedmont, W. Va.							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/61		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. L. Boul				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR JAN 16 1961	
				25b. REGISTRAR'S SIGNATURE Arthur S. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

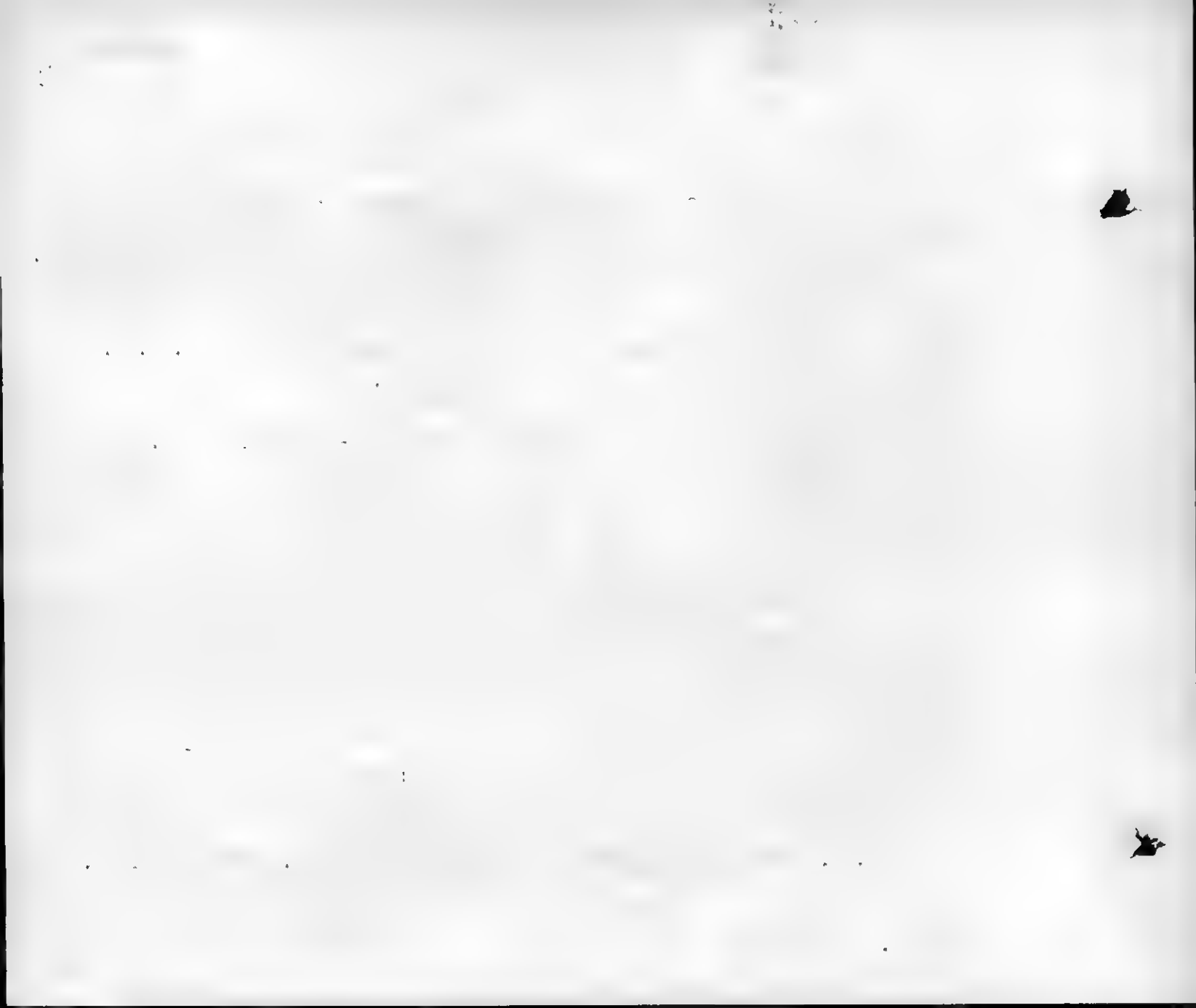


022

00023

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 38 DAYS			
d. NAME OF HOSPITAL (If not hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCISCO Middle FRAGOMENI Last FRAGOMENI				4. DATE OF DEATH Month JANUARY Day 12 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 30, 1882	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		11. IF UNDER 24 HRS Months 78 Days 78 Hours 78 Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) ITALY Caulonia	
13. FATHER'S NAME JOHN FRAGOMENI				14. MOTHER'S MAIDEN NAME TERESA ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-10-2566		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown DUE TO Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Myocardial infarction DUE TO Myocardial infarction DUE TO Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH Days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 12, 1961 to Jan 12, 1961 , that (I) (we) last saw the deceased alive on Jan 12, 1961 , and that death occurred at 2:30 PM the causes and on the date stated above							
22a. SIGNATURE G. Overton Himmelwright				22b. DATE SIGNED 1/13/61			
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-14-61		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				25a. REC'D BY REGISTRAR DATE JAN 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

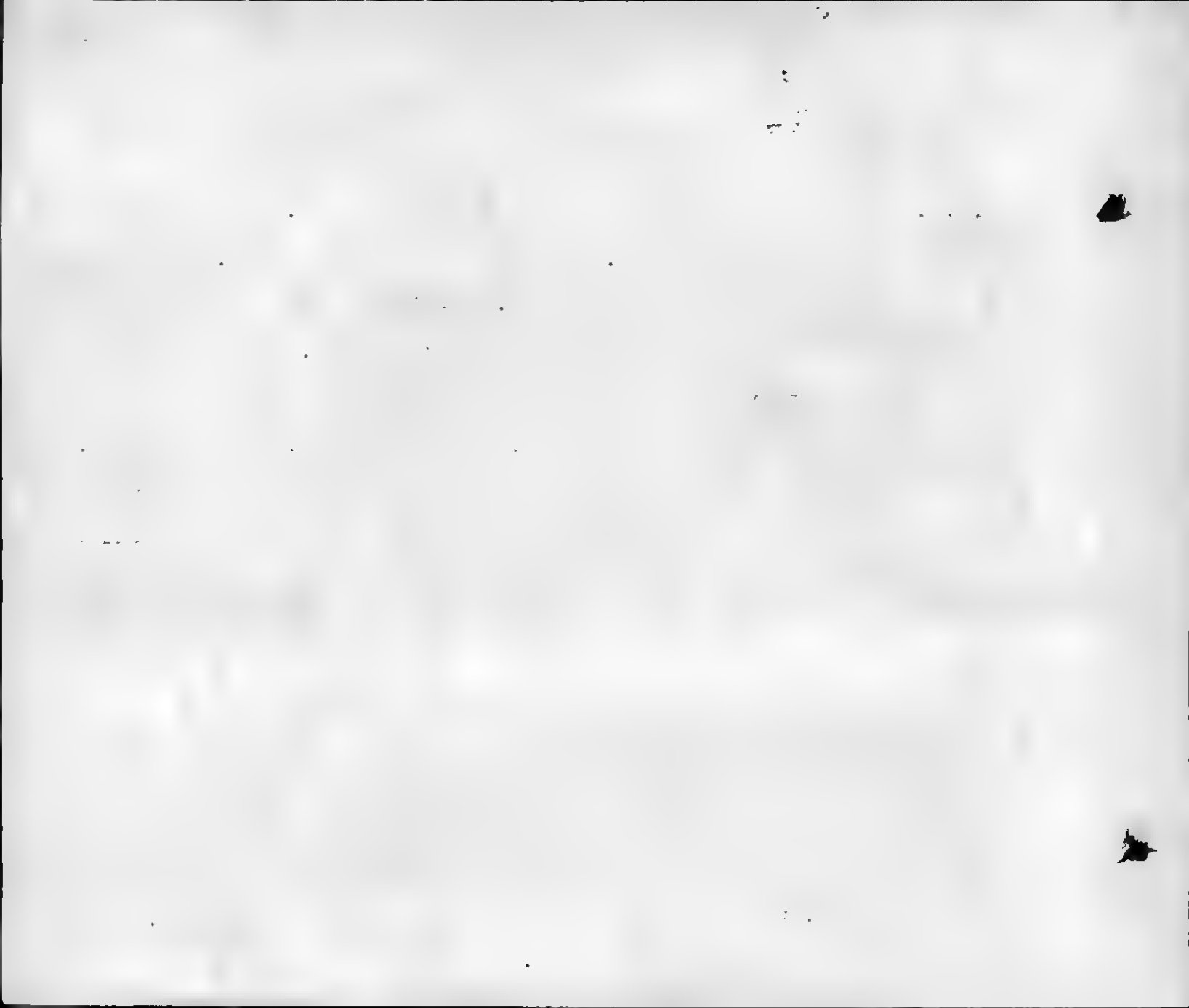
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
c. LENGTH OF STAY IN 1b 41 years				d. STREET ADDRESS 446 Seymour St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George E. Gurtler				4. DATE OF DEATH Month Day Year Jan. 22 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1919	9. AGE (in years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ellis Gurtler				14. MOTHER'S MAIDEN NAME Jane Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) yes (If yes, give war or dates of service) War II		16. SOCIAL SECURITY NO. 219-03-8250		17. INFORMANT Address Mrs. George Gurtler, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEPATIC FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FATTY INFILTRATION OF LIVER DUE TO (c) CHRONIC ALCOHOLISM							INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitaralis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25, 1960		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JAN 31 '61		24b. REGISTRAR'S SIGNATURE C. J. S. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

024

CERTIFICATE OF DEATH

00025

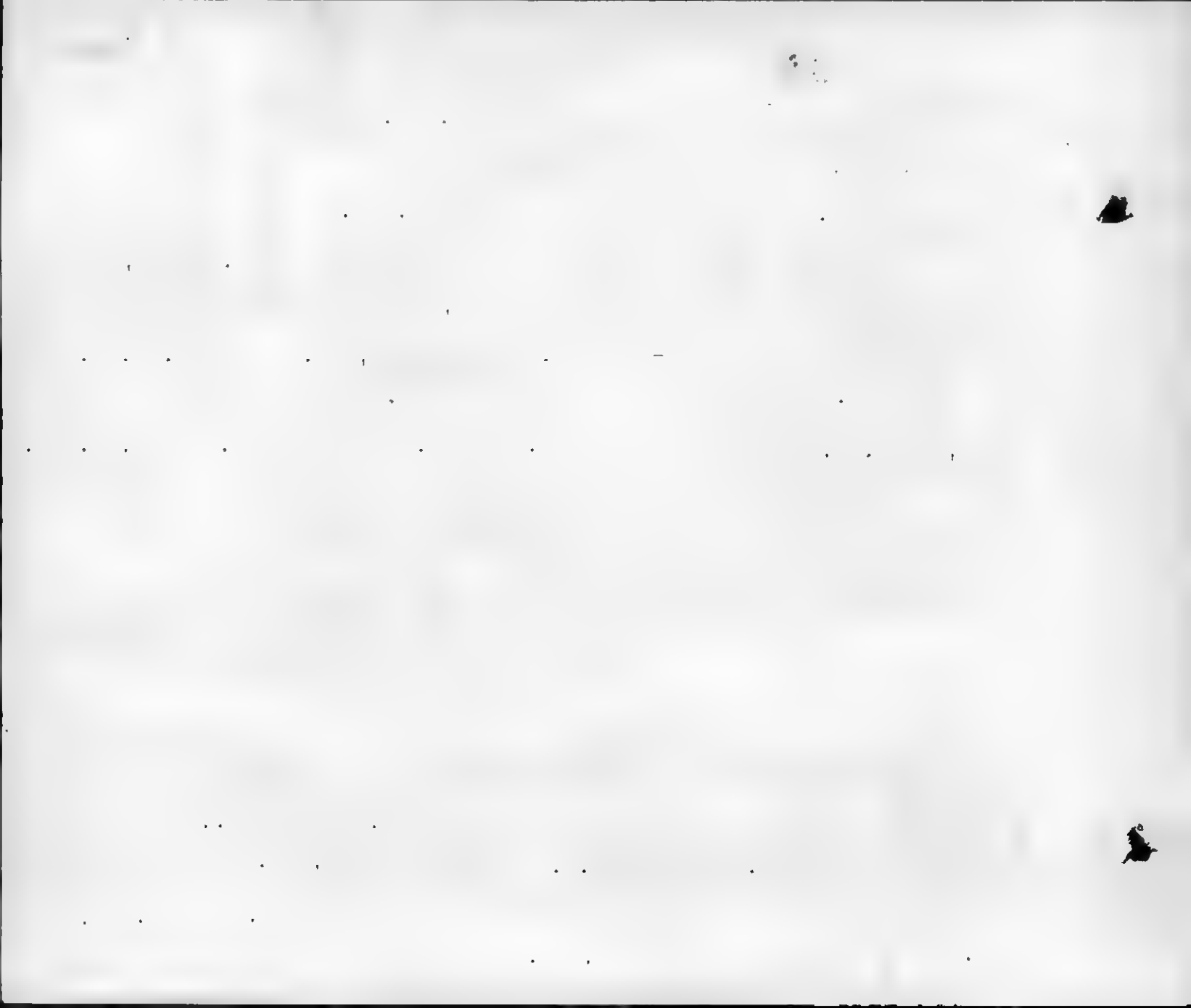
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE W. Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kelly-Tire Co. Infirmary		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Ashby 85X-	
		d. STREET ADDRESS Along St. Rt. # 28	
3. NAME OF DECEASED (Type or print) First FRANCIS Middle McCELLAN Last HAMILTON		4. DATE OF DEATH Month Jan. Day 27 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1900
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis M. Hamilton		14. MOTHER'S MAIDEN NAME Lula R. Little	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes.		16. SOCIAL SECURITY NO. W. W. #2	
17. INFORMANT Mrs. Mary F. Hamilton		Address Ft. Ashby, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - Vent. Fibr. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Cumberland Allegany West	
21. I certify that I attended the deceased from 2/7/55 , 19___, to 1/27/61 , 19___, that I last saw the deceased alive on 1/26/61 , 19___, and that death occurred at 6:20 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard J. Williams M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 122 So. Centre St., 1/28/61	
PHYSICIAN'S NAME (Type) Richard J. Williams M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/30/61	22c. NAME OF CEMETERY OR CREMATORY Arnold Cemetery	22d. LOCATION (City, town, or county) (State) Junction, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JAN 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Finner	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

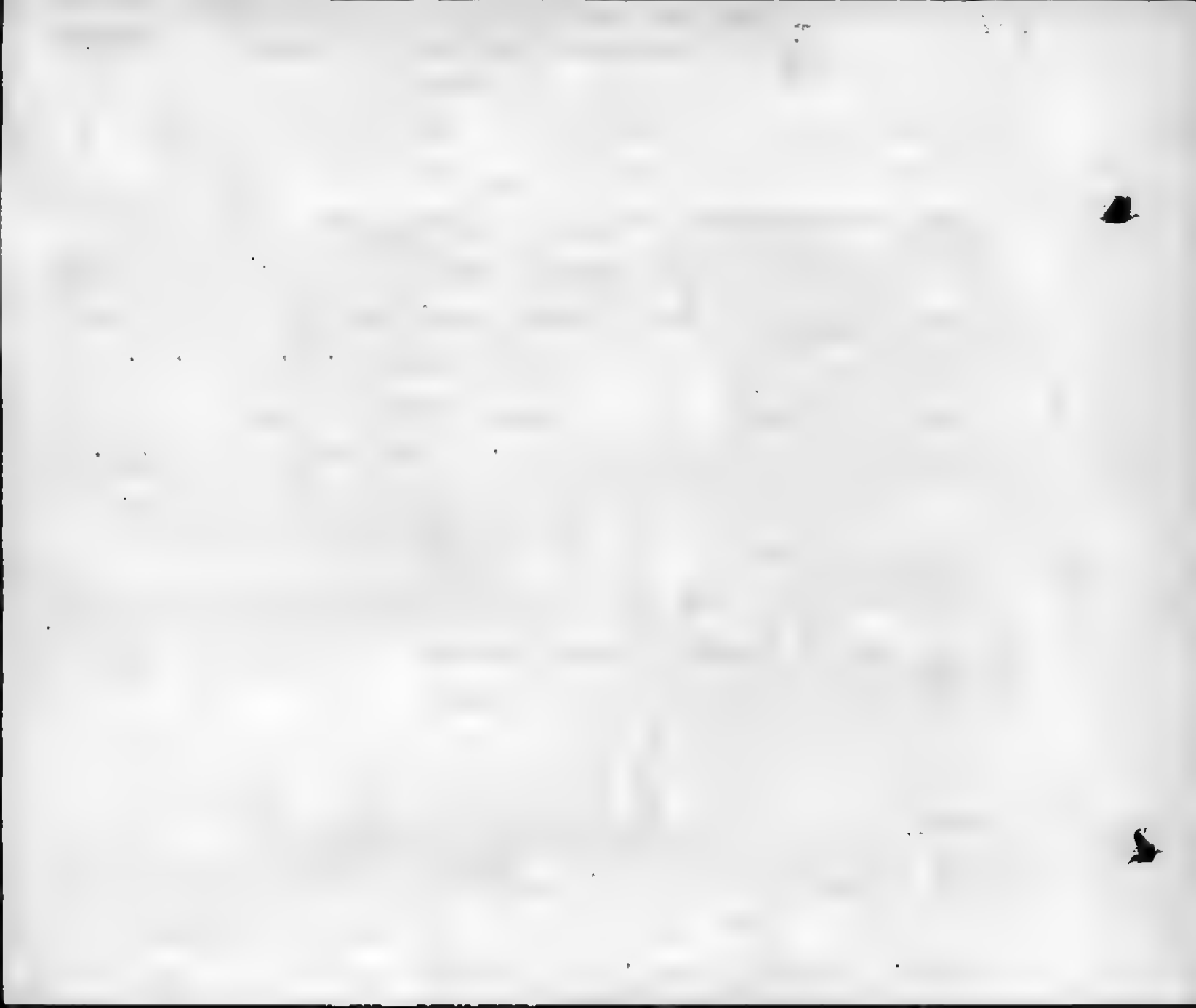
00026

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>70 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Trost Avenue Extended</u>				d. STREET ADDRESS <u>Trost Avenue Extended</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Bell</u> Last <u>Hartman</u>				4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>19 61</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1868</u>		9. AGE (In years last birthday) <u>92 yrs.</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u> Hours <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Burlington, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Miller</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Blackburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mable Rigglesman</u> Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS, PULMONARY EDEMA</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>YEARS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>-----</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.	Month, Day, Year <u>19 61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Cumberland, Maryland</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/8/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 11 1961</u>	
				24b. REGISTRAR'S SIGNATURE <u>John J. Hafer</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. For burial, cremation, or removal.

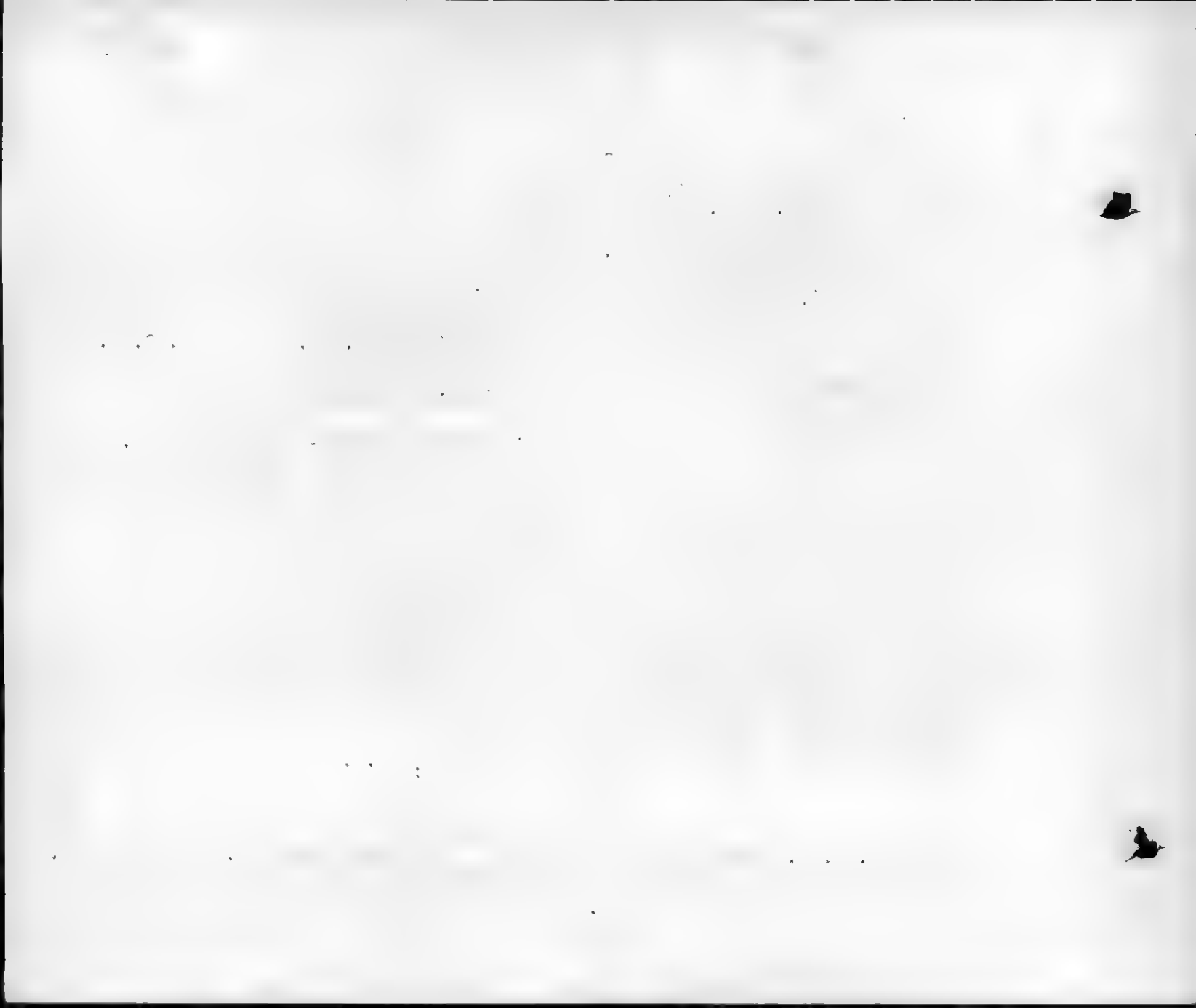


026

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00027

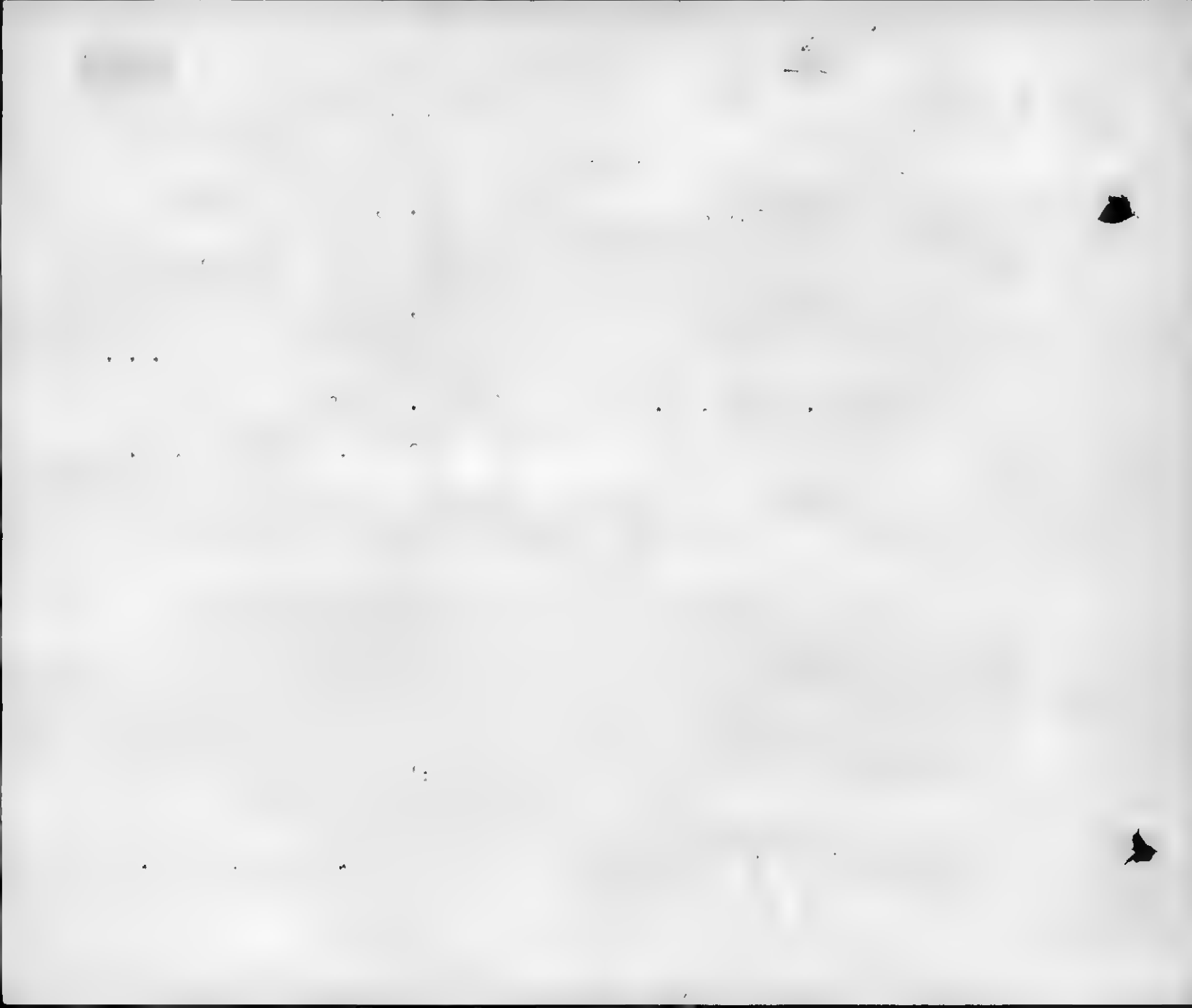
1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. STREET ADDRESS FLINSTONE (ROUTE # 2)			
3. NAME OF DECEASED (Type or print) First MARGIE Middle M. Last HARTMAN				4. DATE OF DEATH Month JANUARY Day 11 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 12, 1911	9. AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) PETERSBURG, W. VA.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BLAIR MONGOLD				14. MOTHER'S MAIDEN NAME SARAH KUYKENDOLL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 153.8 DUE TO Carcinoma of colon, metastatic 7 yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 19--P.M. 19-- that (I) (we) last saw the deceased alive on 19-- and that death occurred at 7:21 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dr. A. J. Mirkin		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN		22d. ADDRESS 115 SOUTH CENTRE ST. CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/61		23c. NAME OF CEMETERY OR CREMATORY New House Cemetery		23d. LOCATION (City, town, or county) (State) Pitt. W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Johnnie Schaffer				25a. REC'D BY REGISTRAR DATE JAN 16 '61		25b. REGISTRAR'S SIGNATURE Charles S. Hines	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
027 CERTIFICATE OF DEATH 00001											
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY							
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY N 1b 55 MINUTES				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				d. STREET ADDRESS RT.#3, PINE RIDGE ROAD				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HEAVNER				4. DATE OF DEATH Month JANUARY Day 8 Year 19 61							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JANUARY 8, 1961		9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME DOUGLAS B. HEAVNER, JR.				14. MOTHER'S MAIDEN NAME SARAH B. THOMAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 7 am Jan 8			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 773.5 DUE TO respiratory failure				CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) pneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town, (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from....., 19...., to....., 19...., that (I) (we) last saw the deceased alive on....., 19...., and that death occurred 10:10 AM from the causes and on the date stated above.											
22a. SIGNATURE Lewis Brings				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS				22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 1-9-61				23c. NAME OF CEMETERY OR CREMATORY Memorial Hospital			
23d. LOCATION (City, town or county) Cumberland, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital, Cumberland, Md				25a. REC'D BY REGISTRAR JAN 10 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

160253X



may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

028

C0028

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 510 Cumberland St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle LEIGH Last HELLER				4. DATE OF DEATH Month Jan. Day 4 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min. —		11. IF UNDER 24 HRS Hours — Min. —		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
13. FATHER'S NAME Charles W. Hammond				14. MOTHER'S MAIDEN NAME Nellie Cabbage			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Charles Heller, Cumberland, Md.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO — (c) — DUE TO —							INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/12/52 to 1/4/61 19 61 that (I) (we) last saw the deceased alive on 1/4/61 19 61 and that death occurred at 6 P. M. from the causes and on the date stated above							
22a. SIGNATURE [Signature]				22b. PHYSICIAN'S NAME (Type) [Signature]		22c. ADDRESS Cumberland, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1/8/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				25a. REC'D BY REGISTRAR JAN 9 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



CERTIFICATE OF DEATH

60029

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE		MARYLAND		b. COUNTY		ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		c. LENGTH OF STAY IN 1b		8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				SACRED HEART HOSPITAL				d. STREET ADDRESS		1			
3. NAME OF DECEASED (Type at print)		First		Middle		Last		4. DATE OF DEATH		Month Year Day			
RHODA		ANN A		HELMSTETTER				JAN		5 19 61			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.			
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3/5/98		62 yrs.		Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE				AT HOME				MARYLAND				U.S.A.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME							
Ambrose Morris						Sarah Neus							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address	
No				220-32-4648				CHART					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 501X DUE TO (b) <u>asthma, obstructive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 days yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, chronic, with atherosclerosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from August 1960 to 1/5 1961, that (I) (we) last saw the deceased alive on 1/4 1961, and that death occurred at 4 AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Elizabeth Brings</u>						22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) DR. ELIZABETH BRINGS						22d. ADDRESS		55 EMMOT GREENE STREET					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)							
Burial		1/9/61		Sts. Peter and Paul's Cem.		Cumberland, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John J. Hafer, Cumberland, Md.						DATE JAN 9 '61		Wm. S. Thomas					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

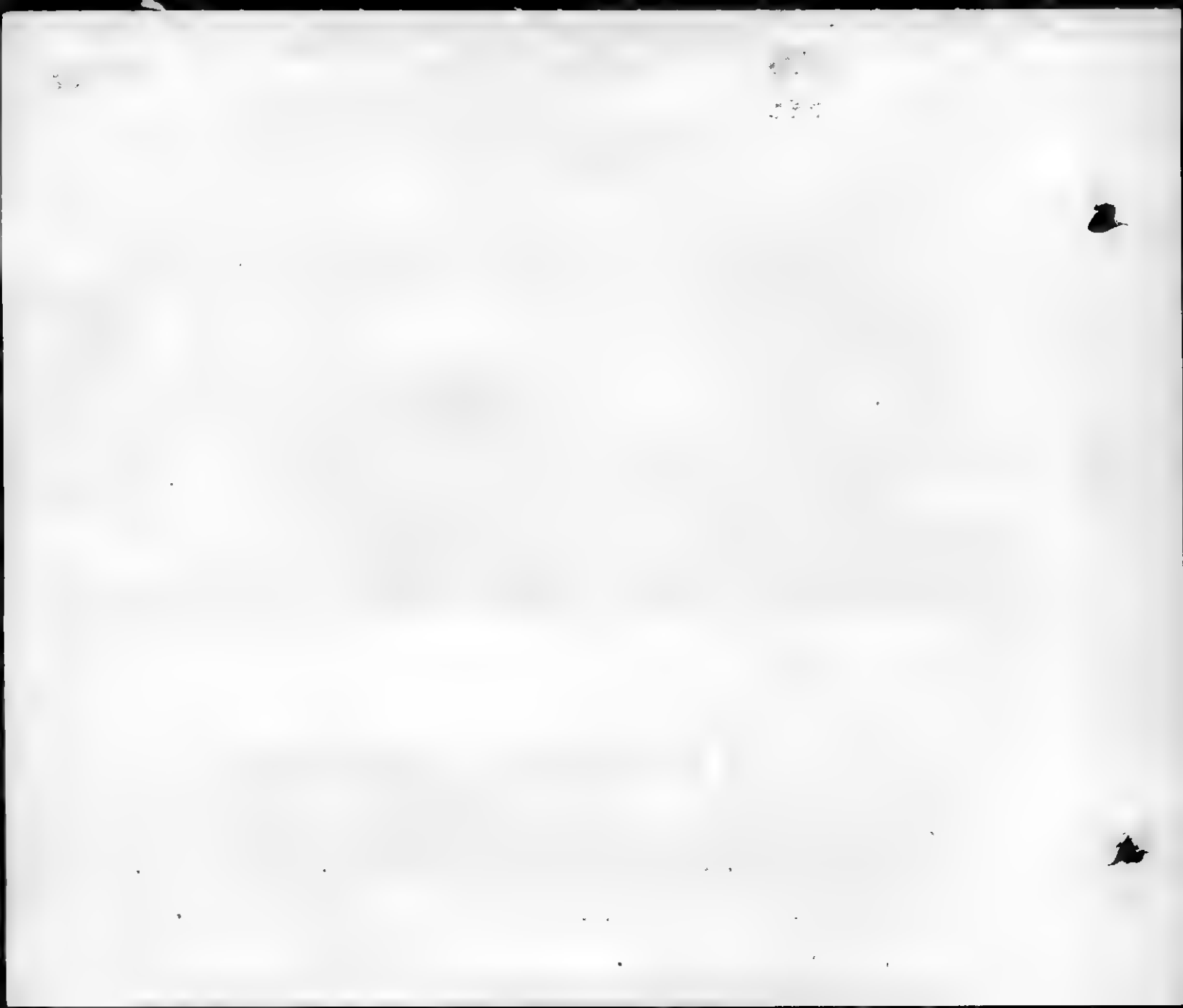
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

030

00030

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FLINTSTONE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOWARD Middle DEWITT Last HEMPRICKSON				4. DATE OF DEATH Month JAN. Day 23 Year 19 61			
5 SEX MALE		6 COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH MAY 30, 1900	
9. AGE (In years last birthday) 60 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASST				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME HOWARD H. HEMDRICKSON				14. MOTHER'S MAIDEN NAME NANCY WENTLING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT PATIENCE CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the sigmoid 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-1-1960 to 1-23-1961 , that (I) (we) last saw the deceased alive on 1-23-1961 , and that death occurred at 4:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE L. Briggs				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LEWIS BRIGGS, M.D.				22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/26/61		23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City, town, or county) (State) Flintstone, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JAN 30 '61		25b. REGISTRAR'S SIGNATURE William S. Hanna	

MEDICAL CERTIFICATION



TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

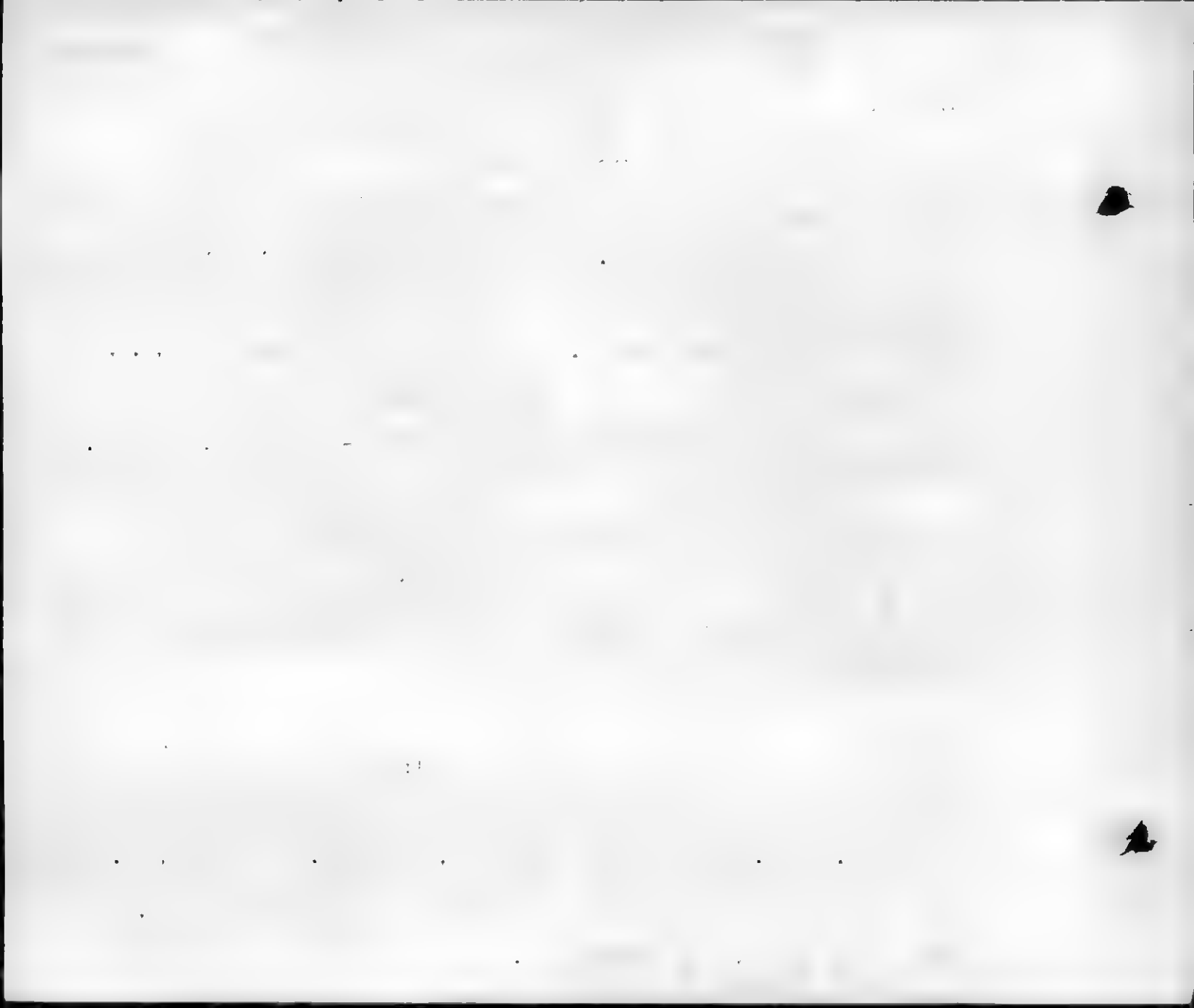
VR AIS (4)
15M 9/59

031

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00031

1 PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 60 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 219 ARCH STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last ESTEL L. HETRICK			4. DATE OF DEATH Month Day Year JANUARY 9 1961				
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 29, 1909	9 AGE (In years lost birthday) yrs. 51	IF UNDER 1 YEAR Months Days 51		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab Co.		11. BIRTHPLACE (State or foreign country) MARYLAND-CUMBERLAND			
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME LLOYD HETRICK			14. MOTHER'S MAIDEN NAME OPAL NIXON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 217-14-4007		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Degeneration					INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11/10			
20f. (City or town) 1960 to 1/9		(County) 1960		(State)			
21 I certify that (I) (this hospital) attended the deceased from 11/10 to 1/9 that (I) (we) last saw the deceased alive on 1/9 19 61 , and that death occurred at 11:50 PM from the causes and on the date stated above							
22a. SIGNATURE Leo H. Ley		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) DR. LEO H. LEY		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-12-1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
23d. LOCATION (City, town, or county) Cumberland, Md.		(State)					
24 FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 13 '61			
25b. REGISTRAR'S SIGNATURE J. S. H. HARRIS							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

032

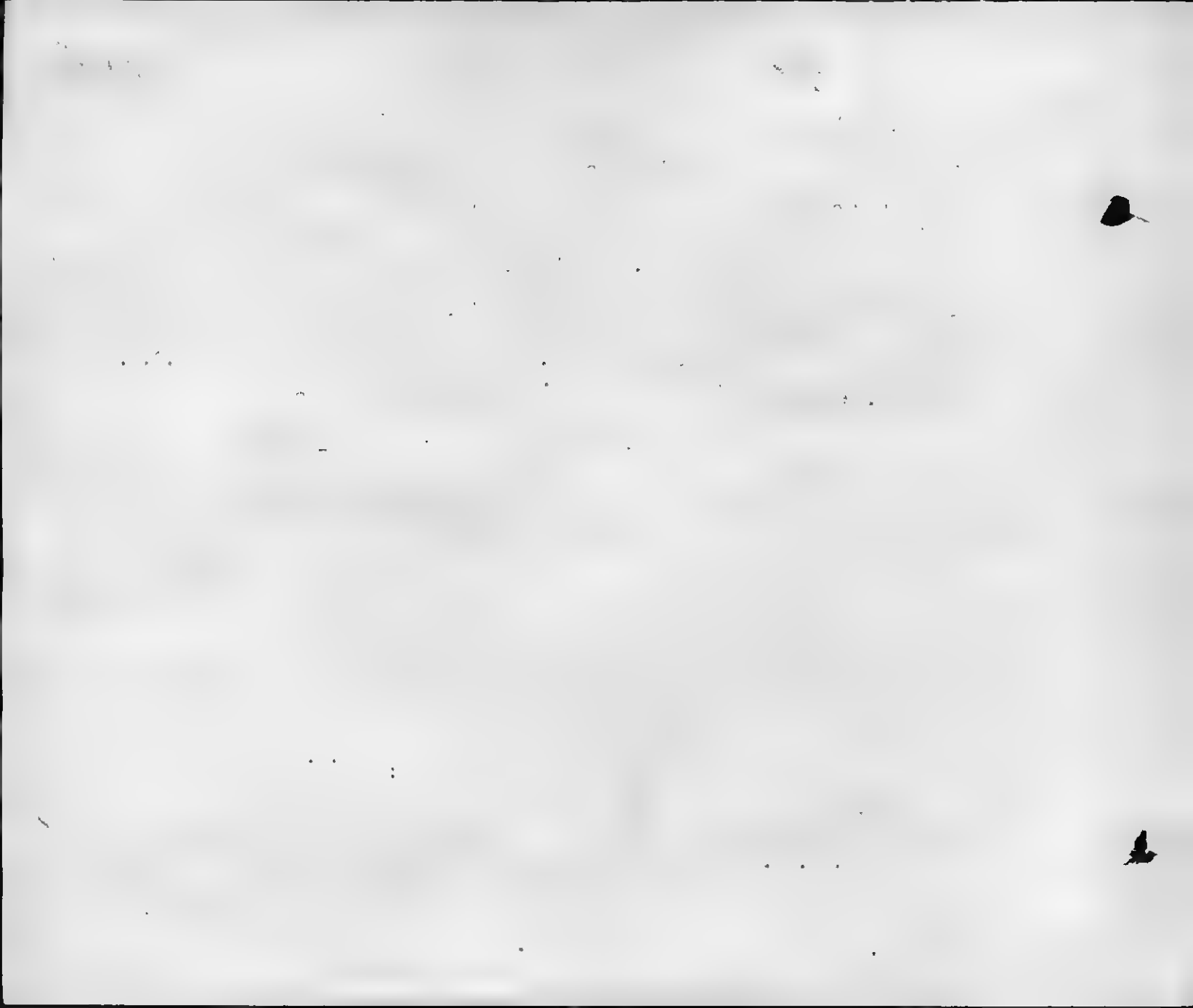
CERTIFICATE OF DEATH

00032

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 41 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 125 NEW HAMPSHIRE AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOHN F. KELLER		4. DATE OF DEATH Month Day Year JANUARY 6 19 61		5. SEX MALE 6. COLOR OR RACE WHITE			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 19, 1903 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST 11. BIRTHPLACE (County & State, or foreign country) GERMANY 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME KELLER, F. Keller		14. MOTHER'S MAIDEN NAME BARBARA SAUNDERS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No 16. SOCIAL SECURITY NO. 217-10-7410 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) _____ DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 15 min.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from Jan 5-9, 1961, 1:59 A.M. Jan 11, 1961 , that (I) (we) last saw the deceased alive on Jan 6, 1961 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.							
22a. SIGNATURE DR. O. G. HIMMELWRIGHT		22b. DATE SIGNED 1/11/61		22c. PHYSICIAN'S NAME (Type) DR. O. G. HIMMELWRIGHT			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-9-61		23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24b. ADDRESS Cumberland, Md.		23d. LOCATION (City, town or county) (State) Cumberland, Md.			
25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE Civil & S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AIME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

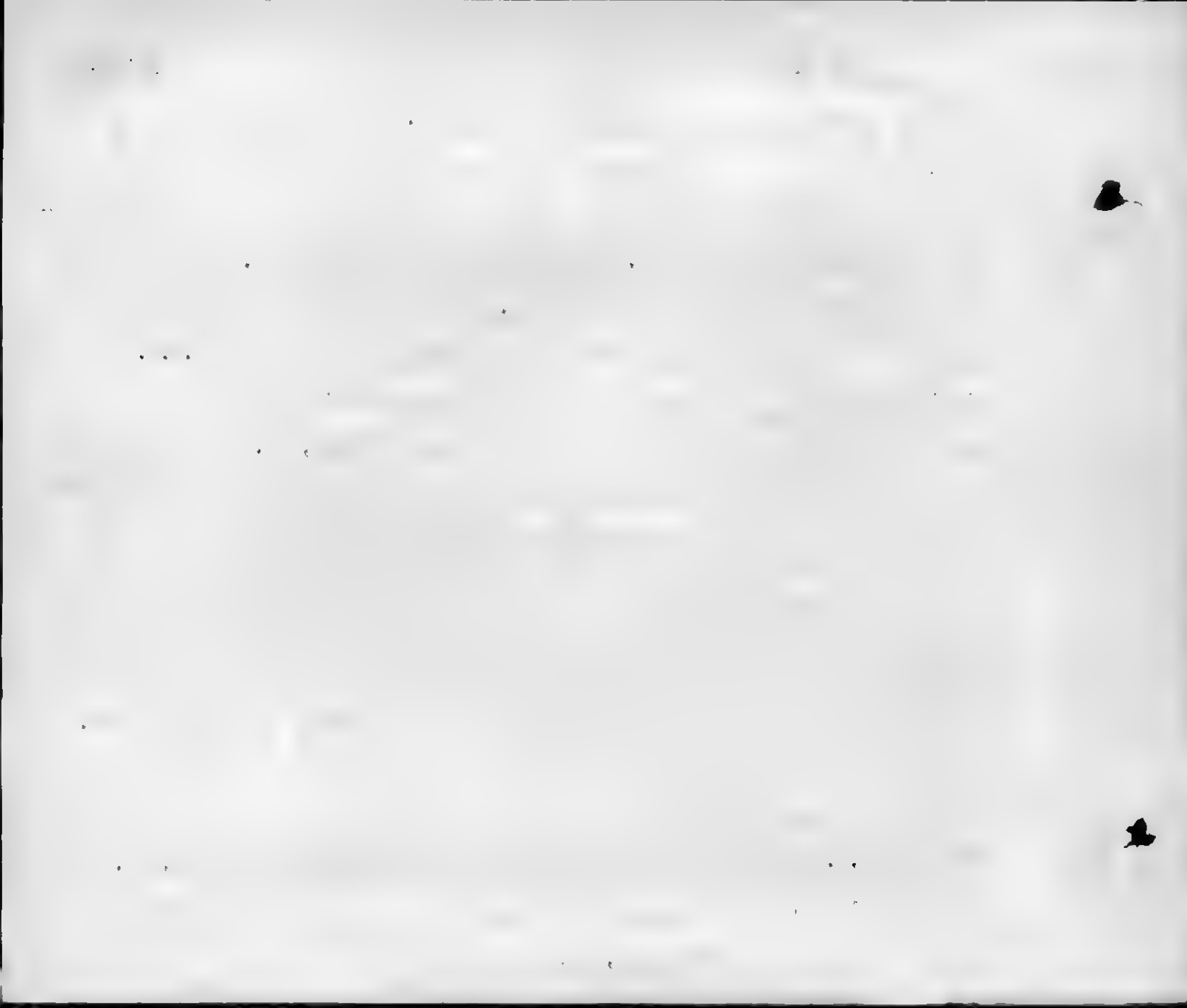
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00002

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		c. LENGTH OF STAY IN IL <u>85 Yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Barton</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>D.</u> Last <u>Keyes</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1875</u>	
9. AGE (in years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrustion</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Phillip Keyes</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Warnick</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mary Keyes Barton, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) _____ b) _____ c) _____							
19. INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>7</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Barton</u>		20f. (City or town) (County) (State) <u>Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE <u>W.O. McLane</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W.O. McLane</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-21-61</u>			
Address (Street, city, town, or county) <u>Frostburg, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>123/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Moscow Md.</u>	
23. FUNERAL DIRECTOR <u>El. Boal</u>				ADDRESS <u>Westernport, Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>JAN 23 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00033**

034

Item B. Filed 79 1-16-61 et

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 65 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Addition				d. STREET ADDRESS Homewood Addition			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last KNIERIEM				4. DATE OF DEATH Month Jan. Day 7 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1874		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 7 Days 7	IF UNDER 24 HRS Hours 7 Min 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael H. Diehl				14. MOTHER'S MAIDEN NAME Mary Howser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Eldon Paxton, Homewood Add. Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION V DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS DUE TO (c) CORONARY SCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 7, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 10, 1961	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JAN 10 '61	24b. REGISTRAR'S SIGNATURE Charles S. House

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

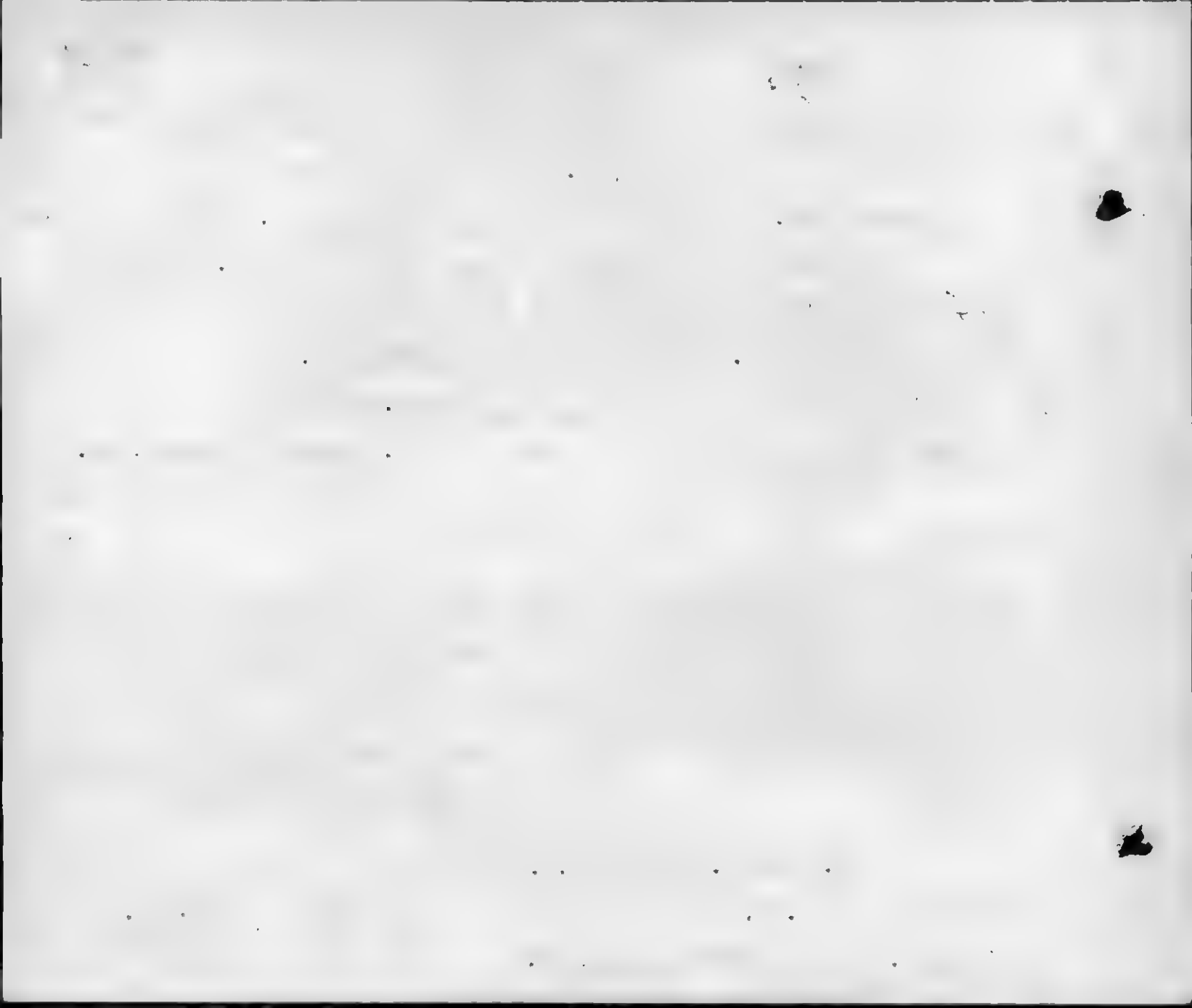


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death).

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
035
CERTIFICATE OF DEATH
C0034

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 27 Grand Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 27 Grand Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Sidney Lewis		4. DATE OF DEATH Month Jan. Day 22 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1870
9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Master Mech. Railroad		10b. KIND OF BUSINESS OR INDUSTRY Middletown, Va.	
11. BIRTHPLACE (County & State, or foreign country) Middletown, Va.		12. CITIZEN OF WHAT COUNTRY? Miss Mabel H. Lewis, Cumberland, Md.	
13. FATHER'S NAME Gordon Lewis		14. MOTHER'S MAIDEN NAME Sara C. Rhodes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Miss Mabel H. Lewis, Cumberland, Md.	
17. INFORMANT Miss Mabel H. Lewis, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (b) Myocarditis (a), stating the underlying cause last, (c) Arteriosclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 yrs. 10 yrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1958 to January 1961 , that (I) (we) last saw the deceased alive on Jan. 18, 1961 , and that death occurred at 10 M, from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett M.D.		22b. DATE SIGNED 236 Va. Ave. Cumberland, Md.	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City, town or county) (State) Stephen City, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

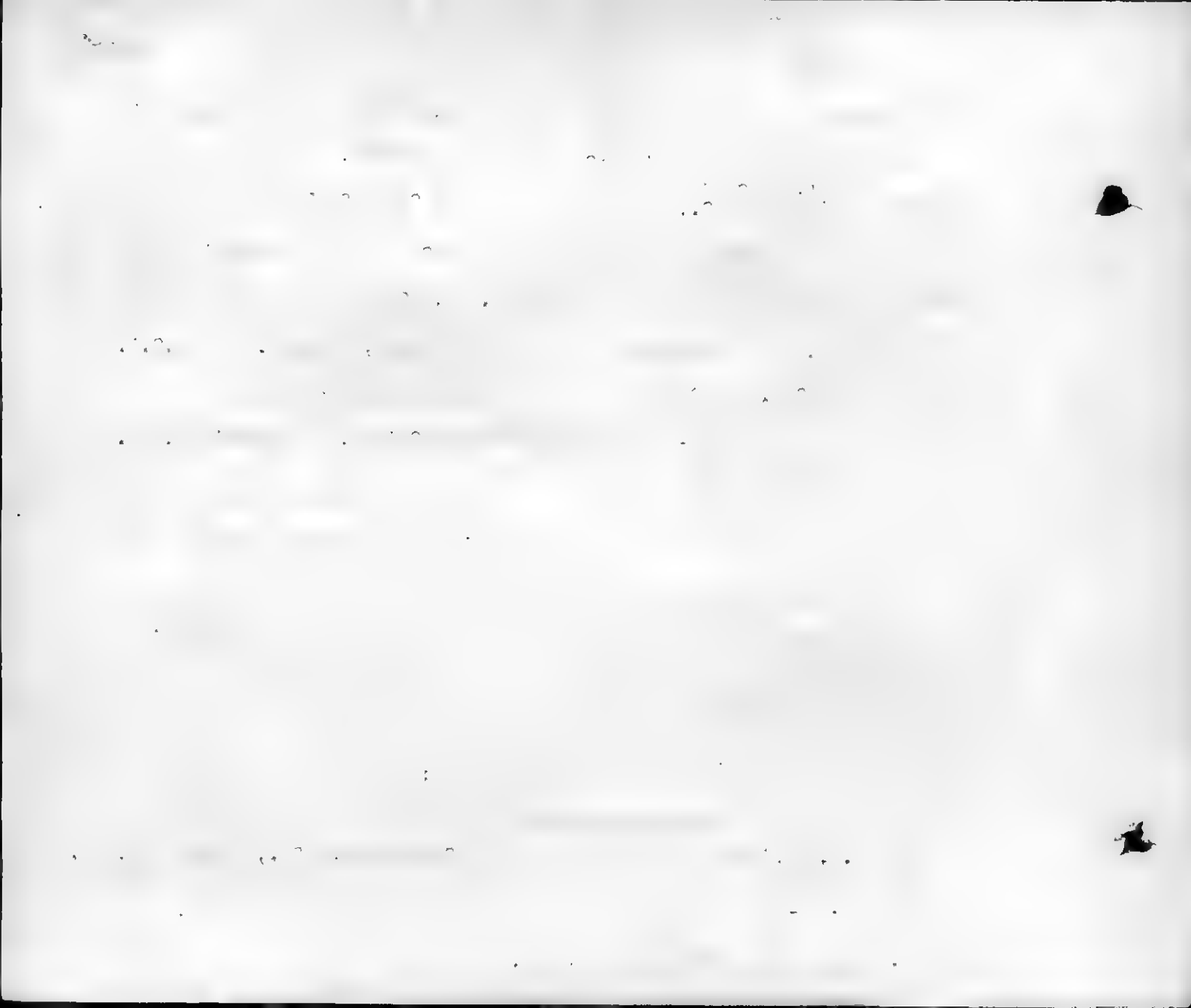
VR A15 (4)
15M 9/59

036

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00035

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 31 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. STREET ADDRESS 47 SOUTH STREET	
3. NAME OF DECEASED (Type or print) First THELMA Middle Last LEWIS		4. DATE OF DEATH Month JANUARY Day 10 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 22, 1906
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES W. JACKSON		14. MOTHER'S MAIDEN NAME FLORENCE VALENTINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-7022	
17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Coronary Artery disease advanced DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 12-10-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-10-60 to 1-10-61 that (I) (we) last saw the deceased alive on 1-10-61 and that death occurred 6:20 AM from the causes and on the date stated above			
22a. SIGNATURE W.F. Williams		22b. DATE SIGNED 1-10-61	
22c. PHYSICIAN'S NAME (Type) W.F. WILLIAMS		22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-13-1961	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 13 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Carlton S. Evans	



may be re-filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

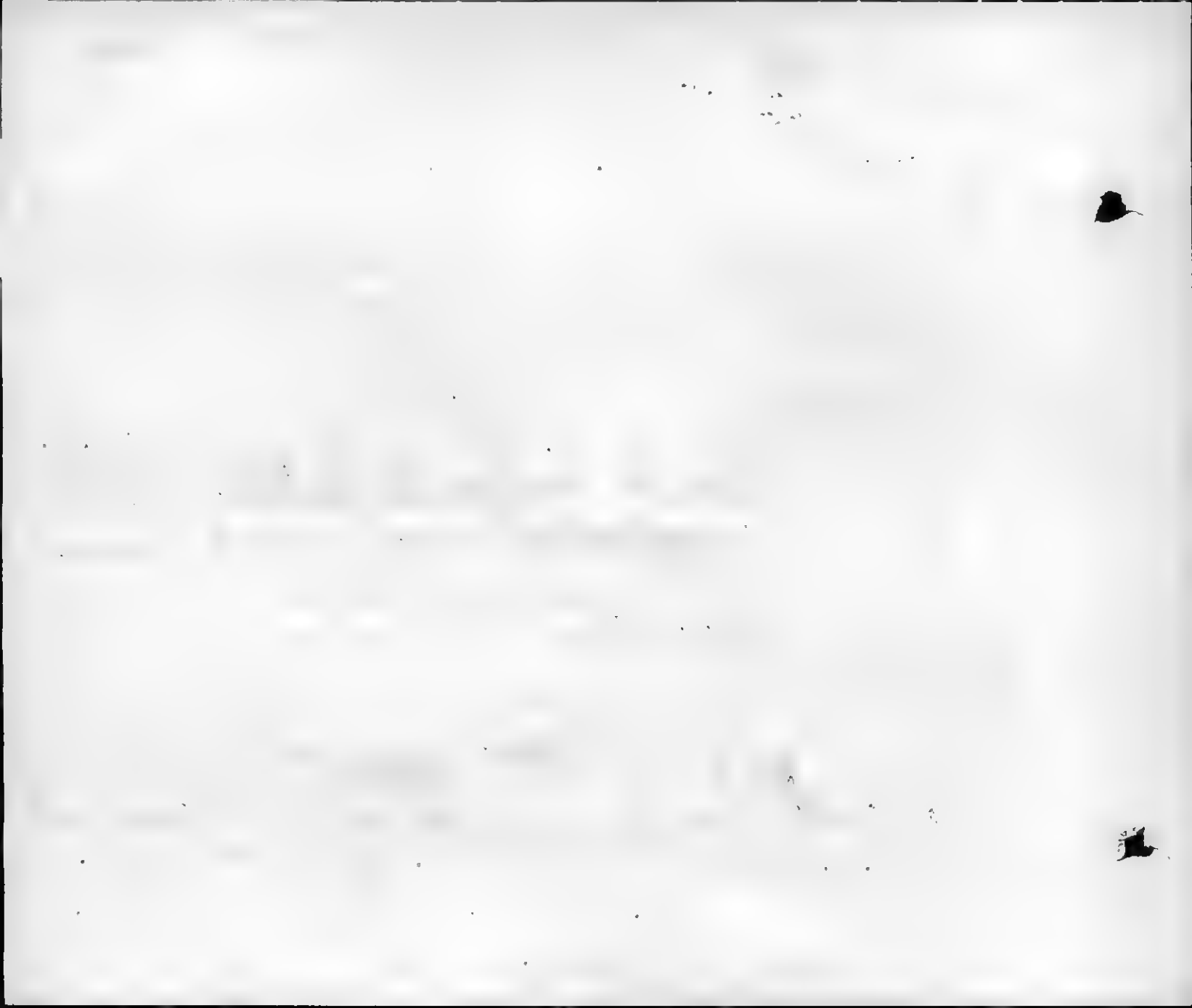
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

037

CERTIFICATE OF DEATH

C0036

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 2, Frostburg				c. LENGTH OF STAY IN 1b 45 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hope Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Jane Last Lohr				4. DATE OF DEATH Month January Day 17th Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22nd, 1887	
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		11. IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own housework		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William Geary				14. MOTHER'S MAIDEN NAME Eliza Jane Poole			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.			
17. INFORMANT J. Edison Lohr, RFD 2, Hope Road, F'bg. Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute Cardiac Dilatation 422.1 DUE TO myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) sudden (c) Several Months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg,				(County) Md.		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1960 to Jan 2, 1961 , that (I) (we) last saw the deceased alive on Jan 14, 1961 , and that death occurred at 7:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE W. O. McLane				22b. DATE SIGNED Jan 18/61			
22c. PHYSICIAN'S NAME (Type) W. O. McLane,				22d. ADDRESS 167 E. Main St., Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-20-61		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE JAN 23 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

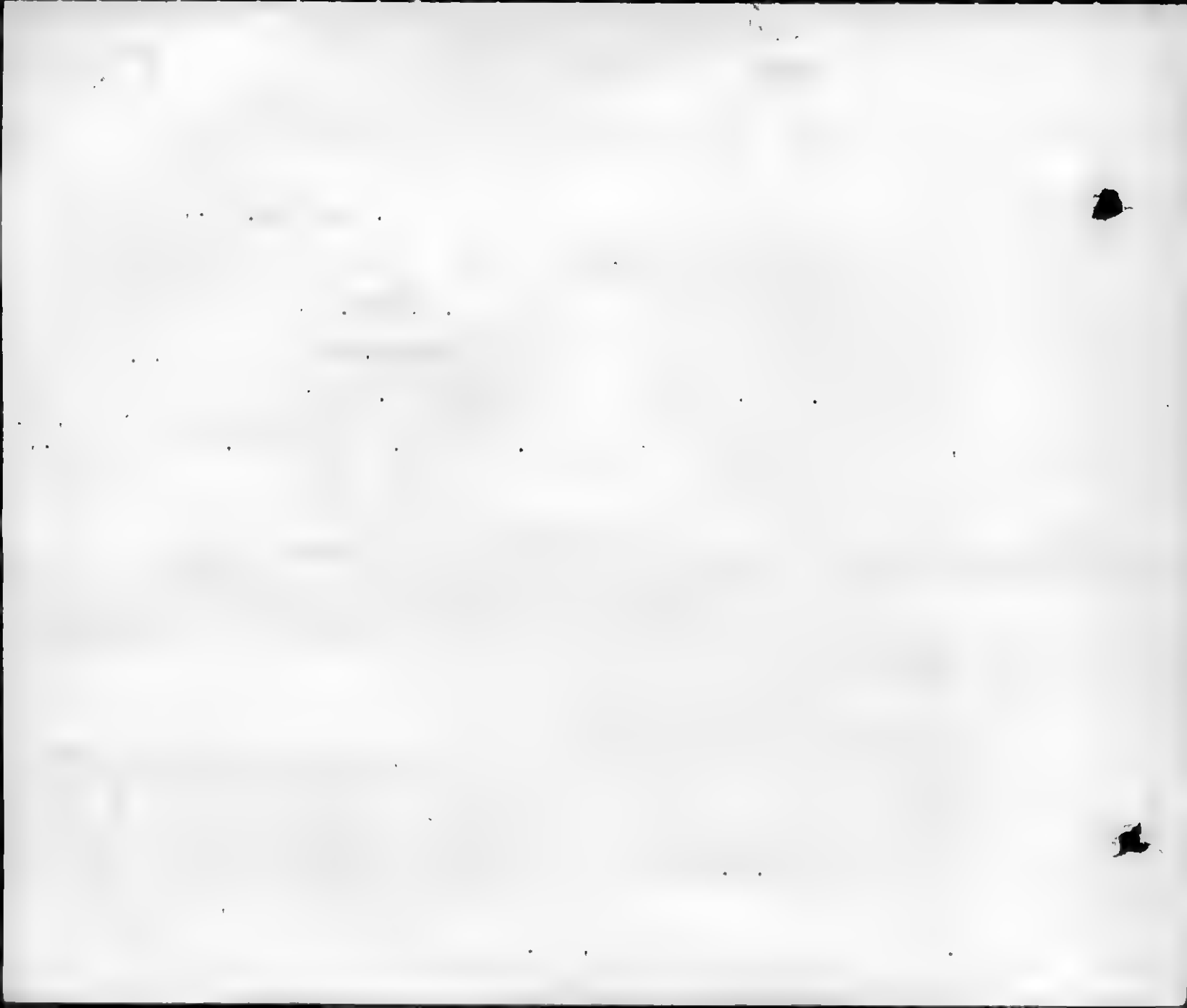
CERTIFICATE OF DEATH

038

C0037

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>711 N. Mechanic St.,</u>	
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Foghtman</u> Last <u>Long</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1st</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 9, 1905</u>
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Weight Master City of Cumberland</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard W. Long</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Darr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>217-18-4994</u>	
17. INFORMANT <u>Mrs. Mabel G. Long</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Renal Failure due Nephrosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u> <u>7 yrs</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic Cirrhosis & Failure secondary Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>1/1</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>60</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above			
22a. SIGNATURE <u>Dr. S. Weisman</u> M.D.		22b. DATE SIGNED <u>1/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. S. Weisman</u>		22d. ADDRESS <u>CUMBERLAND, MD</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	23d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 5 '61</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Wm S. Thomas</u>	

may be returned to the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



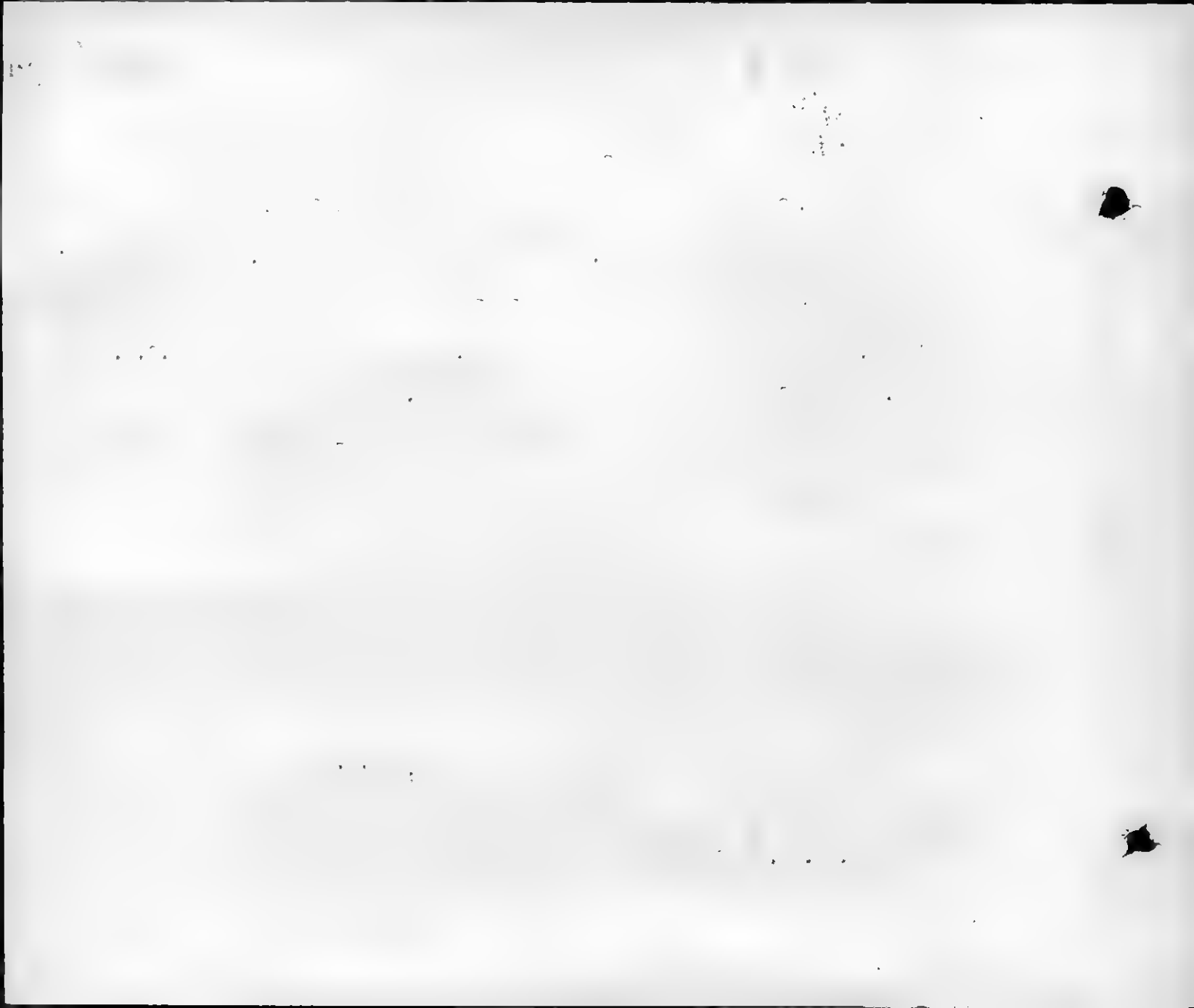
may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
039 CERTIFICATE OF DEATH

00038

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 15 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RENEITH Middle C. Last LOTTIG				4. DATE OF DEATH Month JANUARY Day 13 Year 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-1906	9. AGE (In years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES W. REYNOLDS				14. MOTHER'S MAIDEN NAME ANNA C. CONDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0 Cerebral Edema DUE TO (b) Cirrhosis Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Abdominal Gases							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12:45 P.M. 19 61 , that (I) (we) last saw the deceased alive on 19 and that death occurred on 6:30 A.M. 19 61 , from the causes and on the date stated above.							
22a. SIGNATURE <i>Dr. F. B. Whitworth</i>				22b. PHYSICIAN'S NAME (Type) DR. F. B. WHITWORTH		22c. DATE SIGNED 16 Jan 61	
22d. ADDRESS 123 Bedford St Cumberland Md				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pl		23d. LOCATION (City, town, or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc</i>				25a. REC'D BY REGISTRAR JAN 17 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

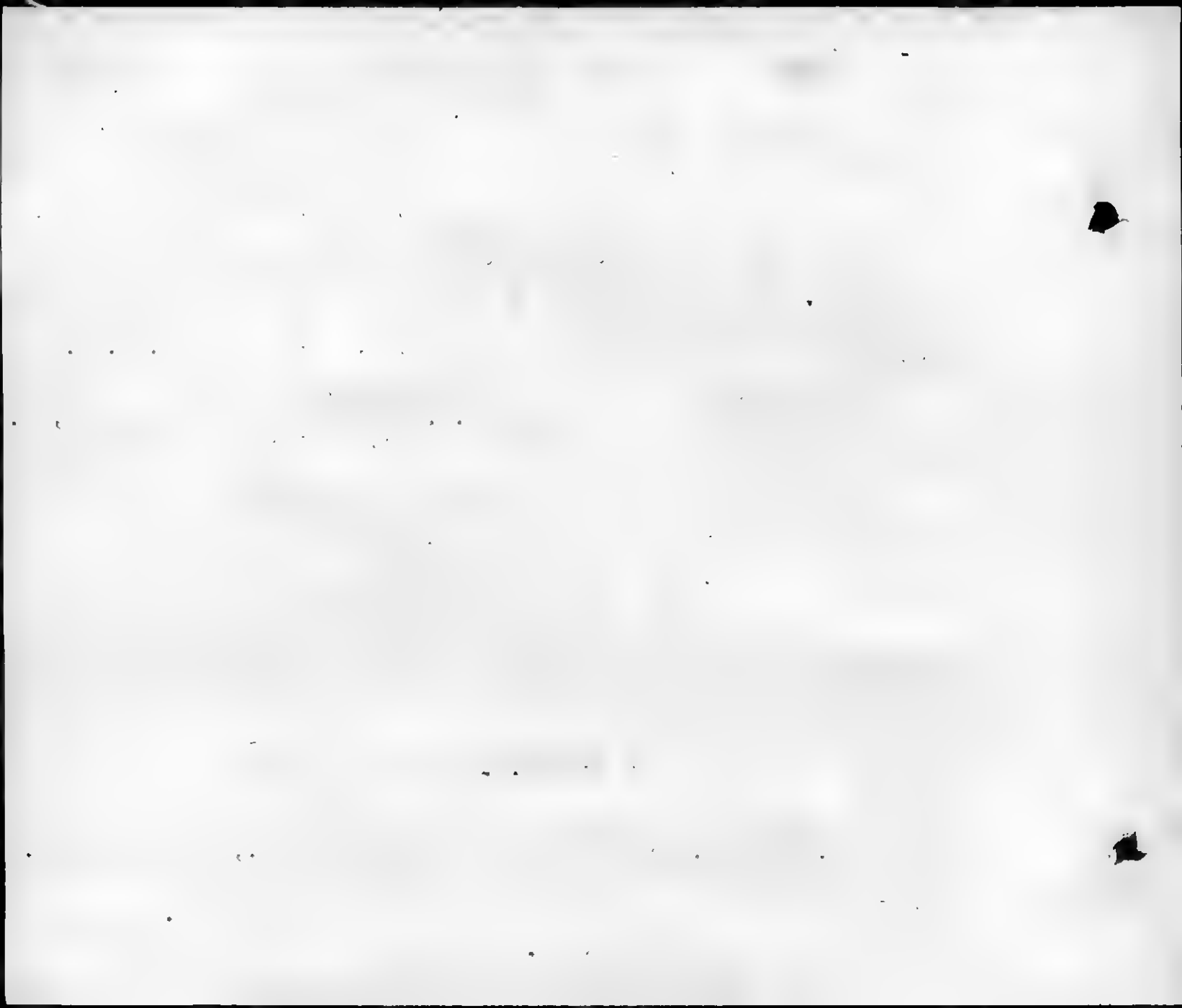
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

040

C0039

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/12/1959	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosa Middle Mae Last Mackay		4. DATE OF DEATH Month January Day 4 Year 1961	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7/8/1868
9 AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Winchester, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Allen		14. MOTHER'S MAIDEN NAME Mary Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		Allegany County Infirmary records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Chronic Nephritis			INTERVAL BETWEEN ONSET AND DEATH ? ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/12/59 , 19____, to 1/4/61 , 19____, that (I) (we) last saw the deceased alive on 1/4/61 , 19____, @ 3:15 P.M. , and that death occurred at ____ M., from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean M.D.		22b. DATE SIGNED 1/4/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/1960	
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS LONACONING, MD.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kane</i>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

60040

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. STREET ADDRESS MT. SAVAGE			
3. NAME OF (Type or print) JOHN F. rs) ANDREW M. dde MALLOY Last				4. DATE OF DEATH JANUARY 7, 19 61			
5. SEX MALE		6. CO. OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 7, 1897	
9. AGE (In years last birthday) 63 yrs.				10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MT. SAVAGE REFRACTORIES			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN T. MALLOY				14. MOTHER'S MAIDEN NAME MARY HATTIE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW 1				16. SOCIAL SECURITY NO. 214-01-0069			
17. INFORMANT MRS. NINA MALLOY, MT. SAVAGE, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4-3-61 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary sclerosis (c) Sudden PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Firstburg Md DATE SIGNED 1-7-61							
ACTUAL SIGNATURE WOMcLane		EXAMINER'S NAME (Type) WOMcLANE MD		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-10-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Savage cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.		24a. REC'D BY REGISTRAR Joseph R. Rust		24b. REGISTRAR'S SIGNATURE Frankburg Md	
23. FUNERAL DIRECTOR Joseph R. Rust				24. REC'D BY REGISTRAR JAN 11 '61			



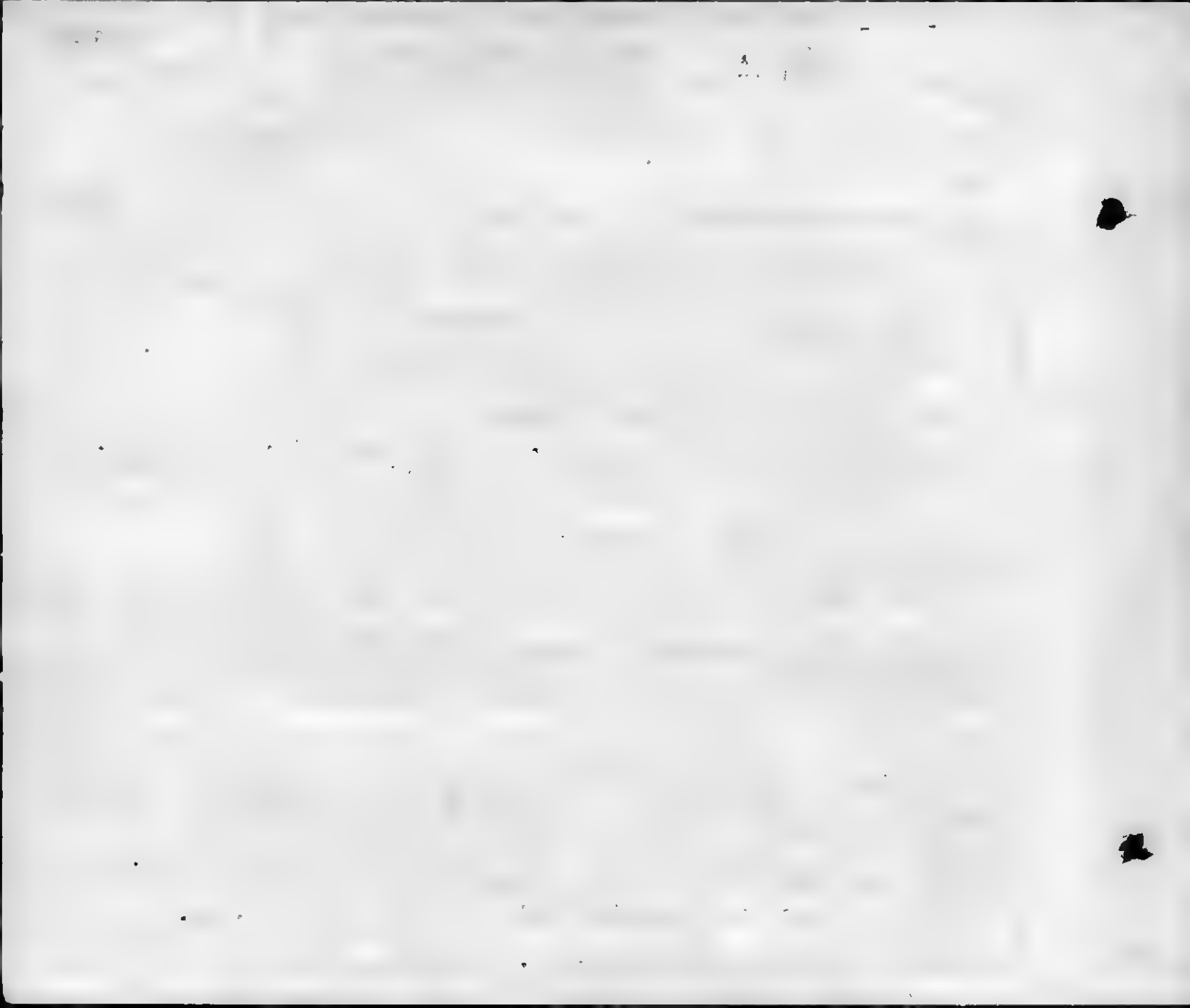
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Items 8,9 fill 6-10 2-9-61 et 042 CERTIFICATE OF DEATH

00041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sumnerland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
c. LENGTH OF STAY IN 1b <u>1 mo., 3 das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1961</u>			
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Bradley</u> Last <u>Marshall</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bradley</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Bradley Marshall, Lonaconing, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331 Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>450 General Arteriosclerosis</u> DUE TO (c) <u>422 Hypocardial Degeneration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 28 H, 1960</u> , to <u>Jan 31 St, 1961</u> , that I last saw the deceased alive on <u>Jan 30 H, 1961</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>49 Greene St.</u> DATE SIGNED <u>James E. McLean</u> ACTUAL SIGNATURE <u>James E. McLean</u> M.D. <u>49 Greene St.</u> PHYSICIAN'S NAME (Type) <u>James E. McLean, M.D.</u> <u>49 Greene St., Lonaconing, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE EICHORN</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 3 '61</u>	
ADDRESS <u>LONA CONING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Kline</u>	



CERTIFICATE OF DEATH

C0042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. SAVAGE</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Church Hill</u>				d. STREET ADDRESS <u>1 Church Hill</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY PAULINE McDERMOTT</u>				4. DATE OF DEATH Month Day Year <u>JAN 3 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 22, 1901</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>William M. Farrell</u>				14. MOTHER'S MAIDEN NAME <u>ANNA PORTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>R. De Sales McDERMOTT - MT SAVAGE</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>							
4:10.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Under occlusion</u>							
DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/5</u> , 19 <u>60</u> , to <u>1/3</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/2</u> , 19 <u>61</u> , and that death occurred at <u>3:00 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>436 N. CENTRE ST.</u>				DATE SIGNED <u>1/4/61</u>			
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u> M.D.				PHYSICIAN'S NAME (Type) <u>LEO H. LEY JR. M.D.</u> <u>Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein</u> ADDRESS <u>117 Federal St</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

044

CERTIFICATE OF DEATH

Item 9-film-279 1-13-61 et

60043

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND g. STREET ADDRESS 32 LAING AVENUE h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CARRIE Middle M. Last MC DONALD		4. DATE OF DEATH Month JANUARY Day 8 Year 1961	
5. SEX FEMALE 6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH OCT. 20, 1898 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND - PICARDY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME ANNA LAYTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 433.1 DUE TO Acute Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (b) Acute Pulmonary Edema (a), stating the underlying cause last. DUE TO Chronic Myocarditis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1957 to Jan 1961 , that (I) (see) last saw the deceased alive on Jan 7, 1961 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE OF PHYSICIAN DR. O.G. HIMMELWRIGHT		22b. DATE SIGNED 1/9/61	
22c. PHYSICIAN'S NAME (Type) DR. O.G. HIMMELWRIGHT		22d. ADDRESS 1331 A Ave Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 11, 1961	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 11 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

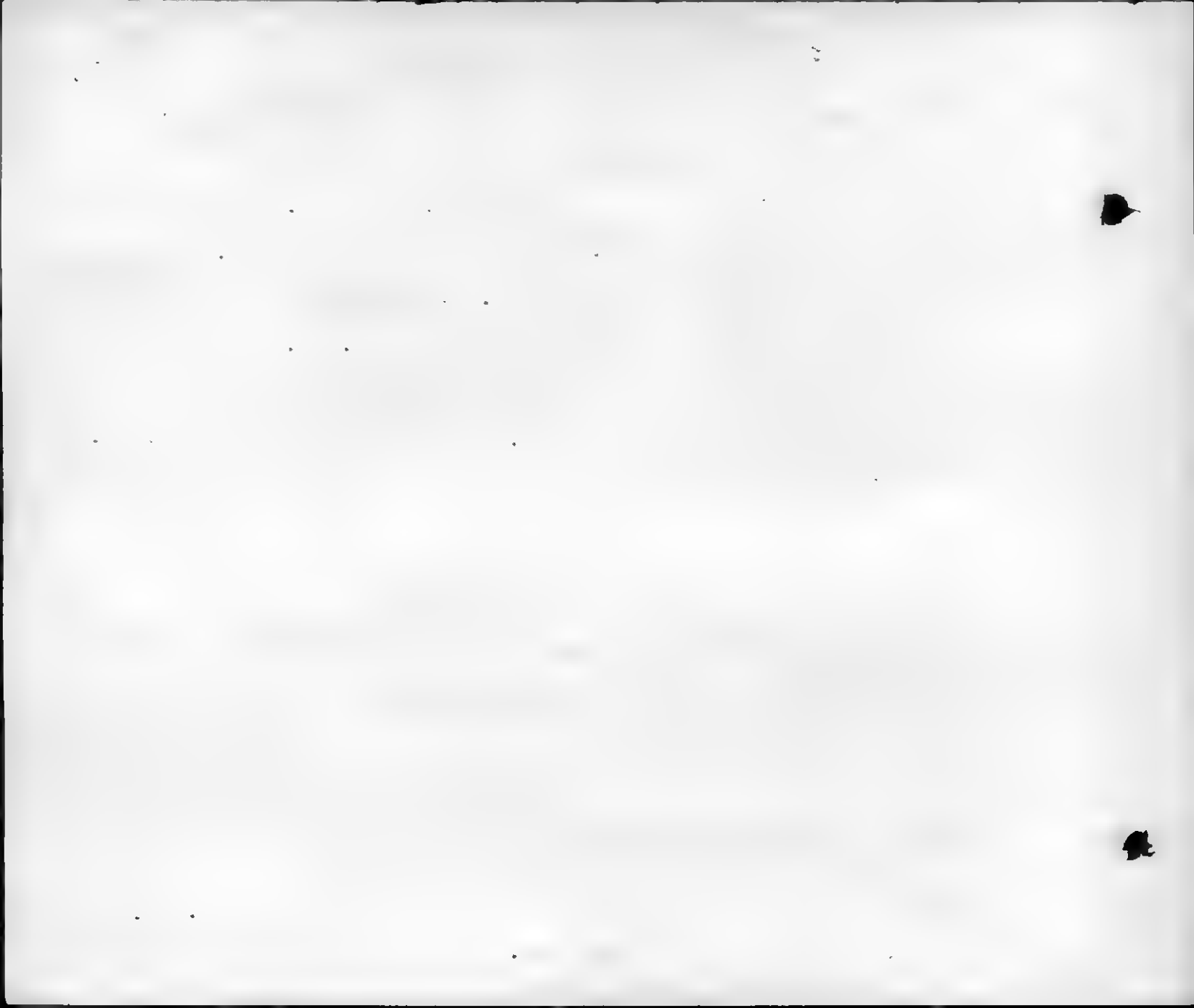


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

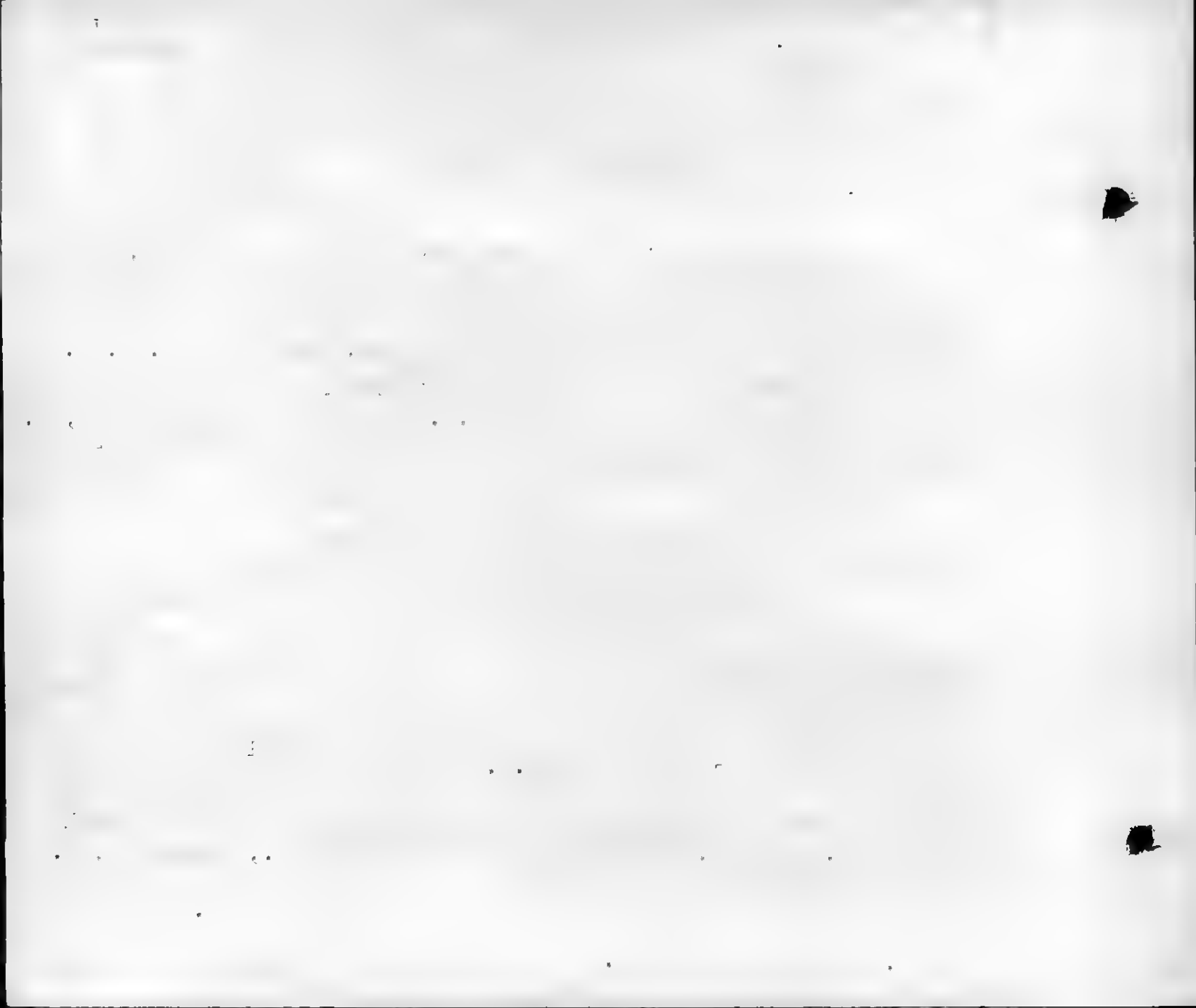
045
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
00044
CERTIFICATE OF DEATH
Item 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN Ib 3 weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 Wempe Drive		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE West Virginia b. COUNTY Harrison c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clarksburg d. STREET ADDRESS 400 Broadus Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle B. Last Mc Guire		4. DATE OF DEATH Month Jan. Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1896
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months 1 Days 6 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Newberne, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Ervin		14. MOTHER'S MAIDEN NAME Alice Westfall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Andrew Saliga, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) 420.1 DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/1 19 61 , to 1/4 19 61 , that (I) (we) last saw the deceased alive on 1/4 19 61 , and that death occurred at 5 P M, from the causes and on the date stated above			
22a. SIGNATURE Leo H. Ley Jr.		22b. DATE SIGNED 1/5/61	
22c. PHYSICIAN'S NAME (Type) LEO H. LEY JR. M.D.		22d. ADDRESS 420 N. Centre St. Cumberland, Md.	
23a. BURIAL CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-61	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCAT ON (City, town, or county) (State) Clarksburg, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
		25b. REGISTRAR'S SIGNATURE Arthur J. Kline	



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I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. STREET ADDRESS 119 Tilghman Street			
3. NAME OF DECEASED (Type or print) First Margaret Middle Askey Last McMurdo				4. DATE OF DEATH Month January Day 8 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1881		9. AGE (In years lost birthday) yrs 79	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Vale Summit, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Askey				14. MOTHER'S MAIDEN NAME Janet Cowan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 215-20-5556		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension 422.2 DUE TO Chronic Myocardial Degeneration? Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO Cerebral Arteriosclerosis? (c) Chronic Arthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Chronic Arthritis							INTERVAL BETWEEN ONSET AND DEATH 36 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6/61 to 1/8/61 19 61 that (I) (we) last saw the deceased alive on 1/7/61 19 61 and that death occurred at 9:55 A.M. M, from the causes and on the date stated above							
22a. SIGNATURE James E. McLean M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/9/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMAT. OR REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				25a. REC'D BY REGISTRAR JAN 11 '61		25b. REGISTRAR'S SIGNATURE C. J. L. Lema	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

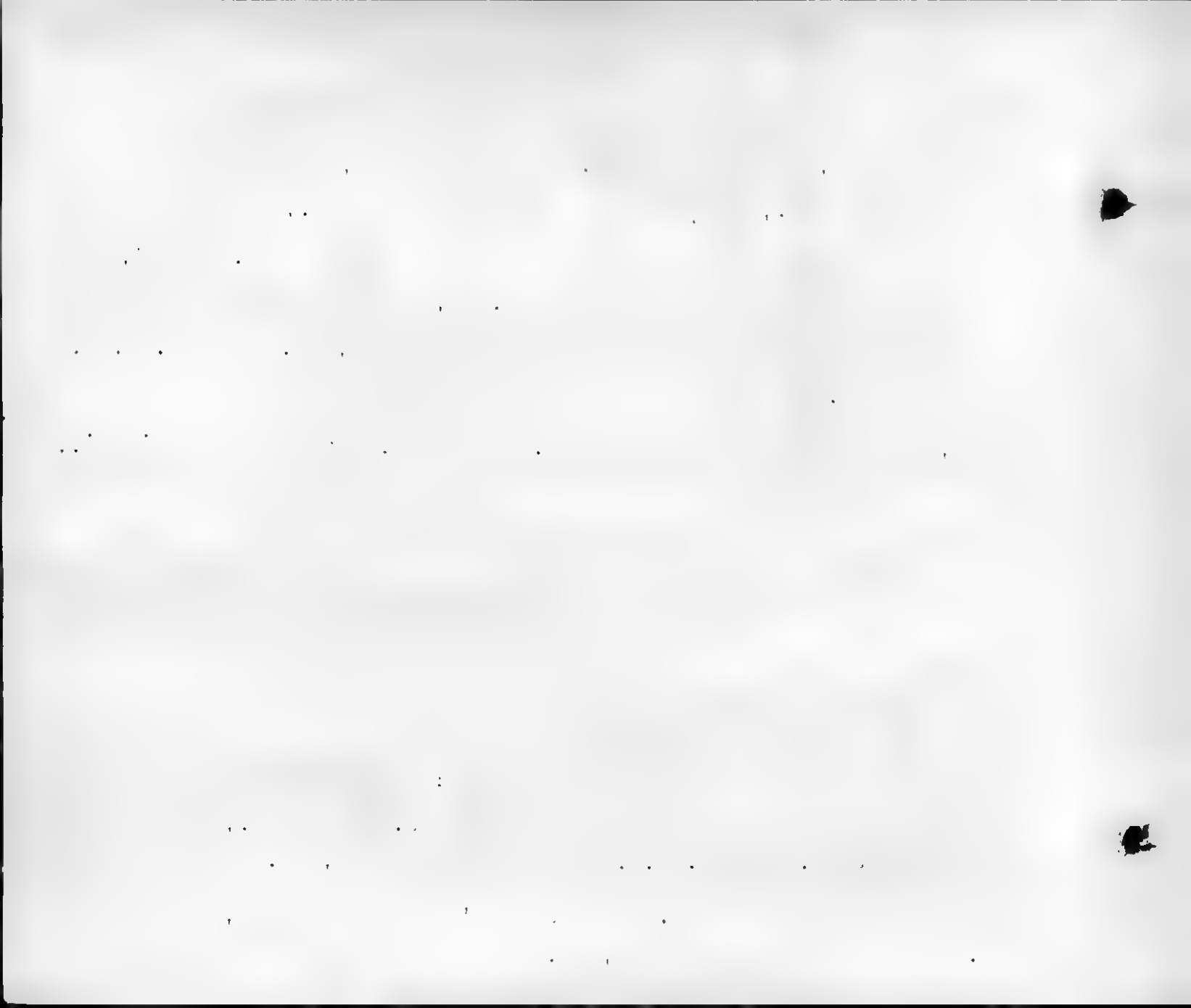
047

CERTIFICATE OF DEATH

C0047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, c. LENGTH OF STAY IN 1b 90 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 730 Greene St.,		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, d. STREET ADDRESS 730 Greene St., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHERINE MARIE MEYERS		4. DATE OF DEATH Month Jan. Day 22, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1870
9. AGE (In years last birthday) 90		10. IF UNDER 1 YEAR Months 90 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony A. Minke		14. MOTHER'S MAIDEN NAME Elizabeth Wegman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Francis A. Meyers		Address Cumb. Md. 730 Greene St.,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X Coronary Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland, Md.	
20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from 1/21 , 19 61 , to 1/22 , 19 61 , that I last saw the deceased alive on 1/21 , 19 61 , and that death occurred at 6:40 PM , from the causes and on the date stated above.		21. ADDRESS (Street, city or town, state) 456 N. Centre St.,	
21. ACTUAL SIGNATURE Leo H. Ley Jr.		21. DATE SIGNED 1/23/61	
21. PHYSICIAN'S NAME (Type) Leo H. Ley Jr. M.D.		21. ADDRESS Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/61	
22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		23. ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR JAN 26 '61		24b. REGISTRAR'S SIGNATURE C. H. S. H. H.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00047

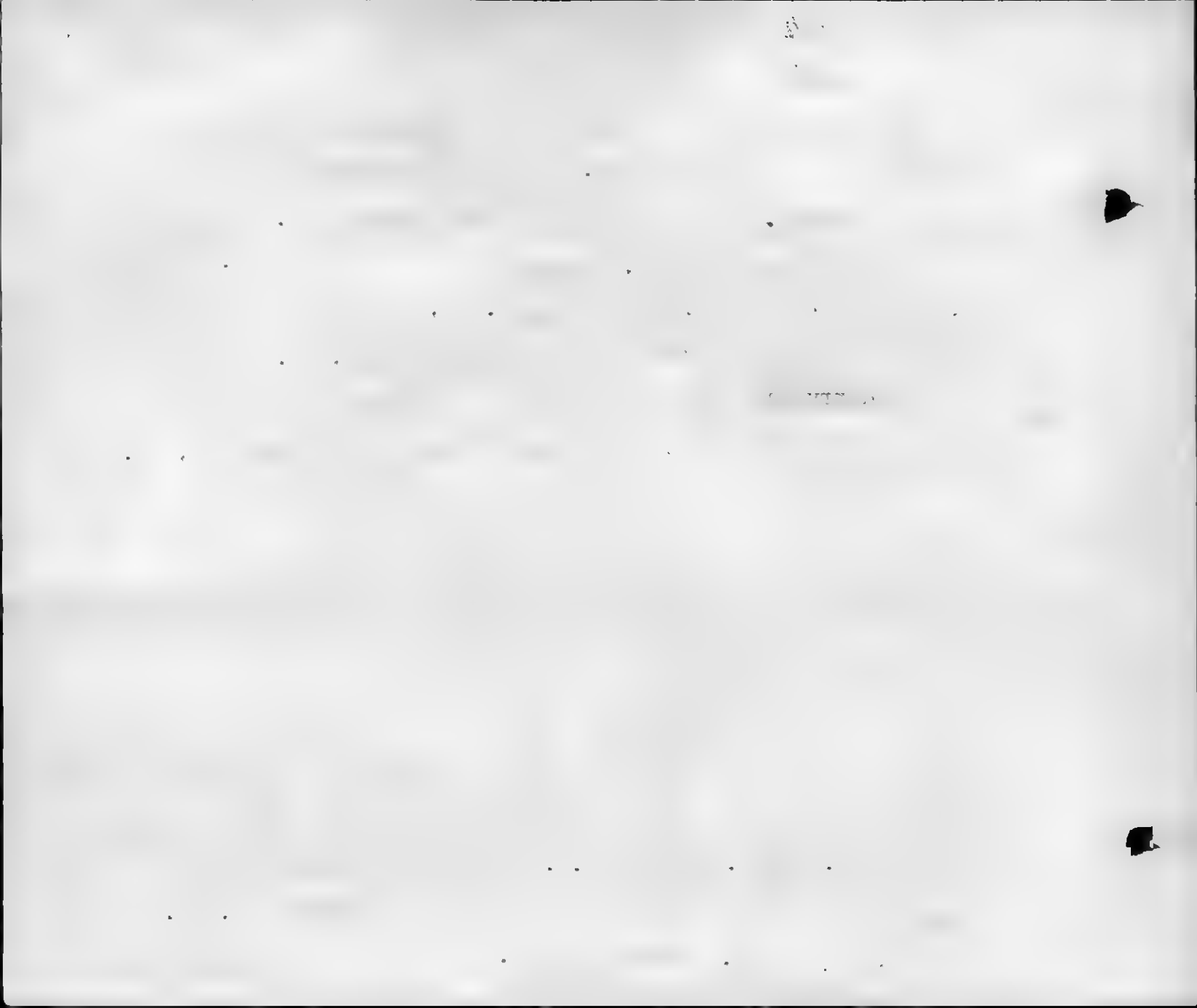
048

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN b. 36 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 229 Cecelia St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 229 Cecelia St.	
3. NAME OF DECEASED (Type or print) Harry G. Minnigh		4. DATE OF DEATH Jan. 31 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1883
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Telegraph Operator Railroad		9. AGE (In years last birthday) 77	
11. BIRTHPLACE (County & State, or foreign country) Duncansville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Minnigh		14. MOTHER'S MAIDEN NAME Carrie ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-8123	
17. INFORMANT Gilbert Minnigh, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 29, 1961 to Jan. 31, 1961 ; that (I) (we) last saw the deceased alive on Jan. 29, 1961 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED 2/1/61	
22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.		22d. ADDRESS 236 W. 4th St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1961	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

049 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

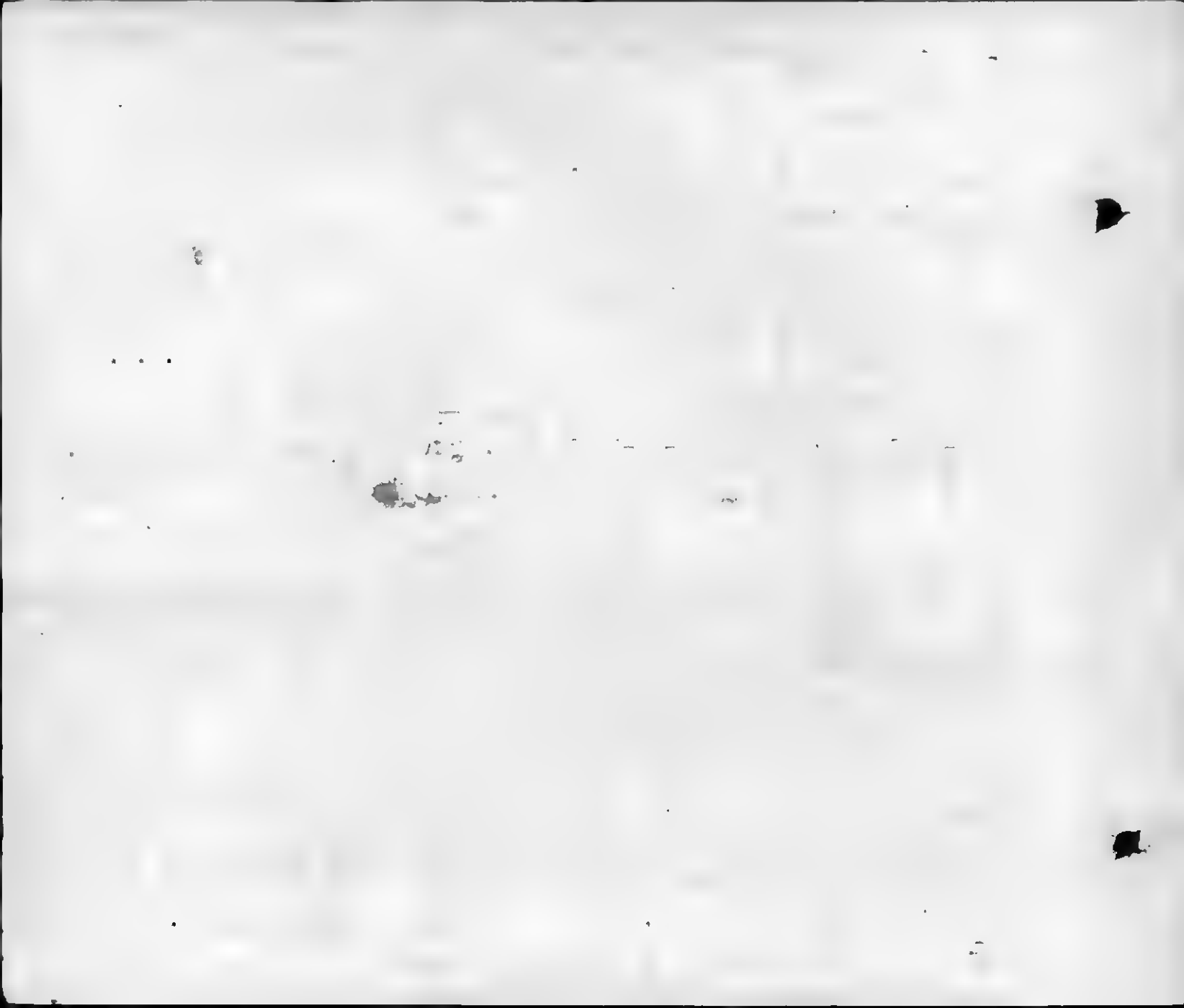
60048

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 65 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES MONAHAN				4. DATE OF DEATH Month 1/ Day 7/ Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/1895		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John Monahan				14. MOTHER'S MAIDEN NAME Mary Freal			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-World War 1				16. SOCIAL SECURITY NO 220-10-1061		17. INFORMANT Mrs. Anna Monahan, Lonaconing, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation DUE TO myocardial insufficiency Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (b) 7 years (c) Sudden				INTERVAL BETWEEN ONSET AND DEATH 7 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE WOMcLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-7-61			
EXAMINER'S NAME (Type) WOMcLane MO		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER Firstburg Md			
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/1960		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. F. H. R. DIRECTOR'S SIGNATURE George Czekhon, Lonaconing, Md				24a. REC'D BY REGISTRAR 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

050

CERTIFICATE OF DEATH

00049

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Maners Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) R.D.#1 (Carlos) Frostburg d. STREET ADDRESS IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HUGH MORGAN First Middle Last		4. DATE OF DEATH Jan. 30th 19 61 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1919
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY Hospital	
11. BIRTHPLACE (County & State, or foreign country) Carlos		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Morgan		14. MOTHER'S MAIDEN NAME Alice Speir	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-6904	
17. INFORMANT Mw. Morgan, R.D. #1, Box 198, Frostburg, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) Myocardial Infarction Coronary sclerosis + previous infarction 20 mos + Diabetes Mellitus (brittle) 25 yrs. Acute Tracheitis	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cond. (b) gave rise to immediate cause (a), setting the underlying cause last. DUPLICATE		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Acute Tracheitis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg		20g. (County) Allegany	
20h. (State) Md.		21. I certify that (I) (this hospital) attended the deceased from..... 3/19 .. 1959, to.. 1/30 .. 1961, that (I) () last saw the deceased alive on..... 1/30 .. 1961, and that death occurred at 5:30 PM, from the causes and on the date stated above.	
22a. SIGNATURE Frank T. Harra		22b. DATE SIGNED 1/30	
22c. PHYSICIAN'S NAME (Type) FRANK T. HARRAT		22d. ADDRESS 26 W. Mechanic St., Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-61	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg		23d. LOCATION (City, town or county) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		25a. REC'D BY REGISTRAR FEB 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kenna		25c. REGISTRAR'S SIGNATURE Arthur L. Kenna	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

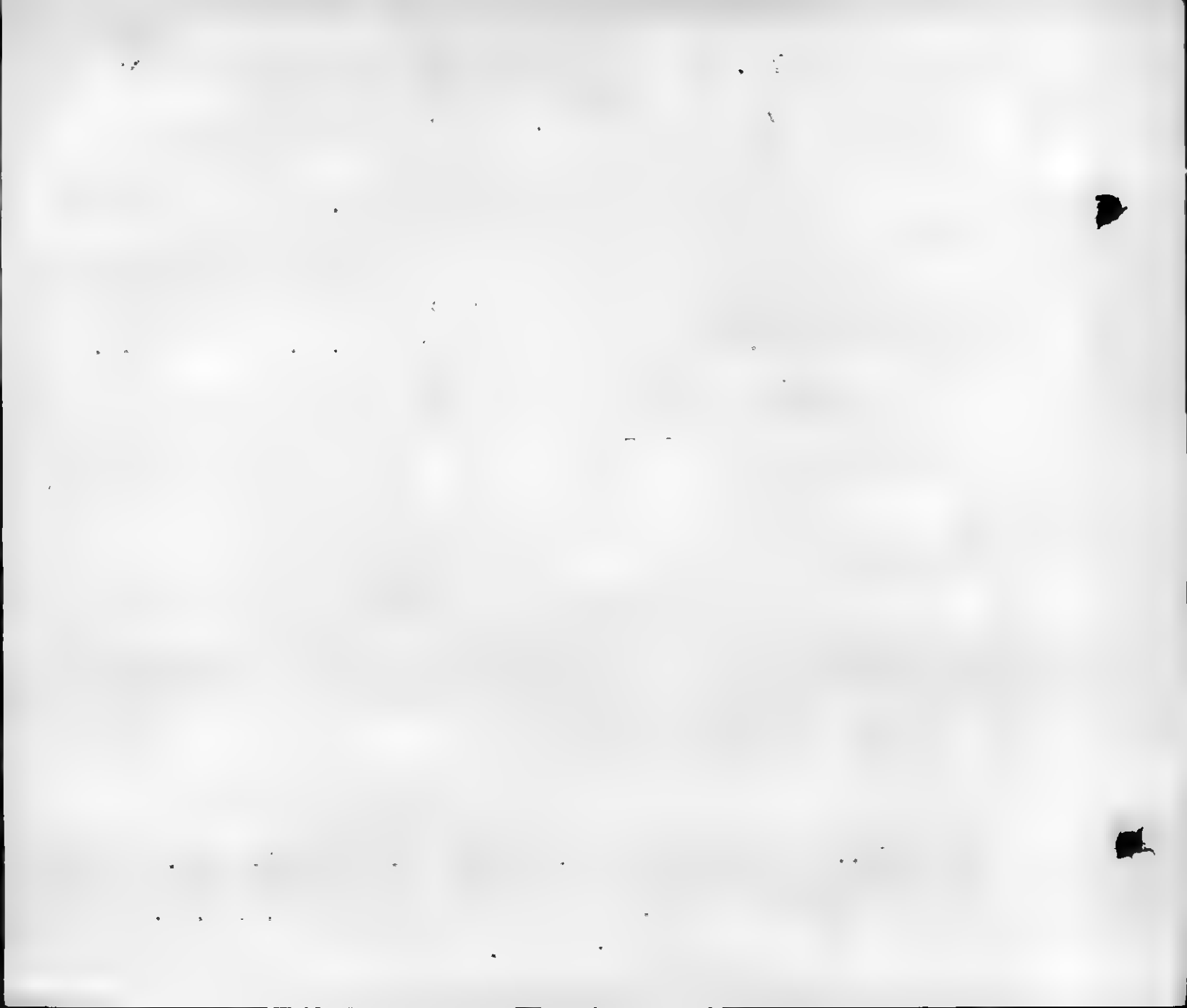
051

CERTIFICATE OF DEATH

00050

Reg. Dist. No

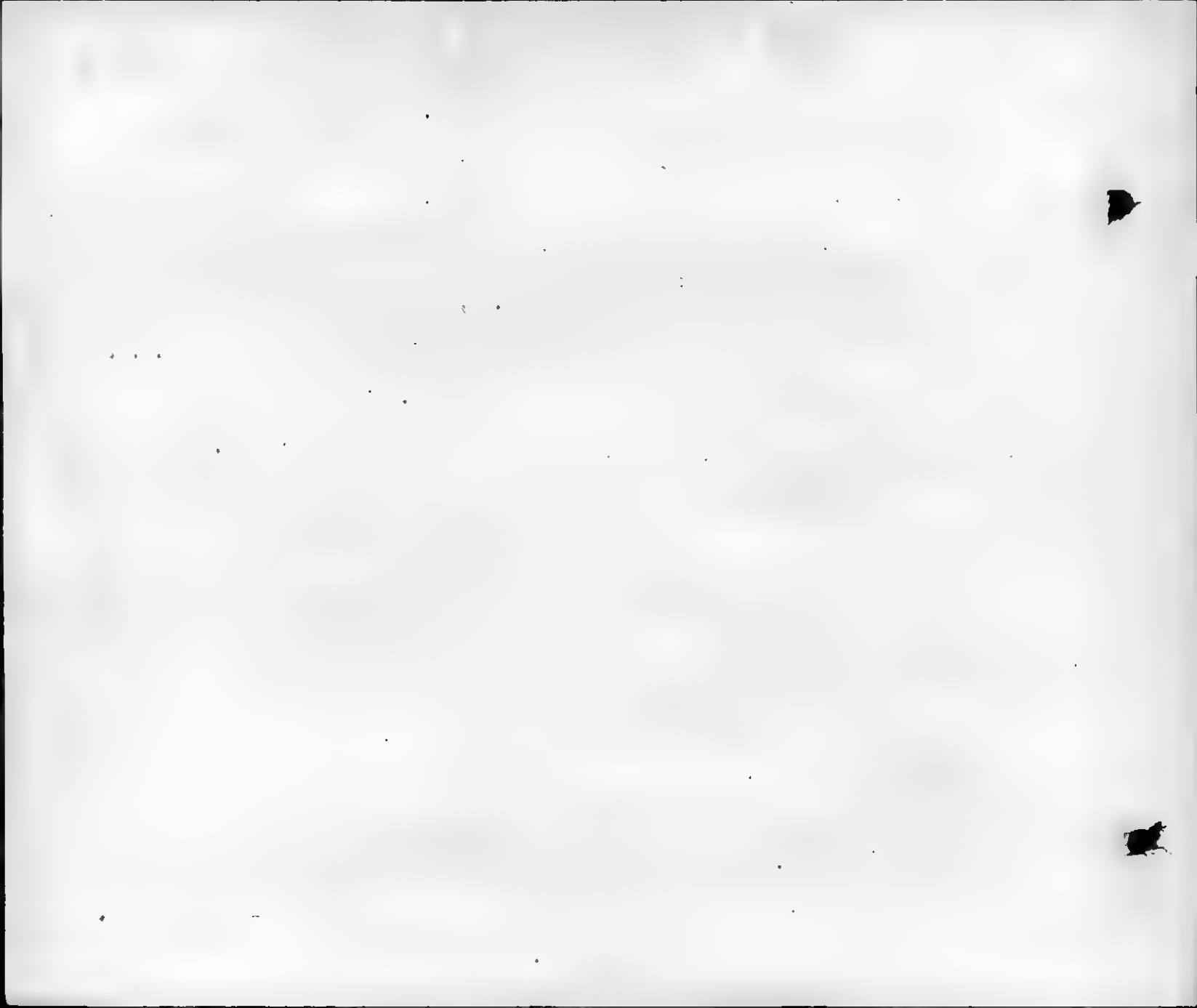
1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE W. VA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUKE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CITY BUILDING		d. STREET ADDRESS 58 Third St.	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN J ose MUNSIE		4. DATE OF DEATH Month Day Year JAN 4 19 61	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 17, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE FCR.		10b. KIND OF BUSINESS OR INDUSTRY CITY OF LUKE	
11. BIRTHPLACE (State or foreign country) PIEDMONT, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES MUNSIE		14. MOTHER'S MAIDEN NAME AMELIA JOSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-14-5604	
17. INFORMANT Mrs LENA Munsie Piedmont W. Va		Address 58-3rd St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1961 to Jan 4, 1961 , that I last saw the deceased alive on Jan 2, 1961 , and that death occurred at 7:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE James H. Wolverton, M.D.			
PHYSICIAN'S NAME (Type) Jas. H. Wolverton Md. Green St. Piedmont, W. Va. 1/4/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/6/61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Keyser R.D. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Fredlock Jr. ADDRESS Piedmont, W. Va.		24a. REC'D BY REGISTRAR DATE JAN 9 '61	
24b. REGISTRAR'S SIGNATURE Charles S. Kraus			



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052
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
Item 4-111-1-2-20-01 et

C0051

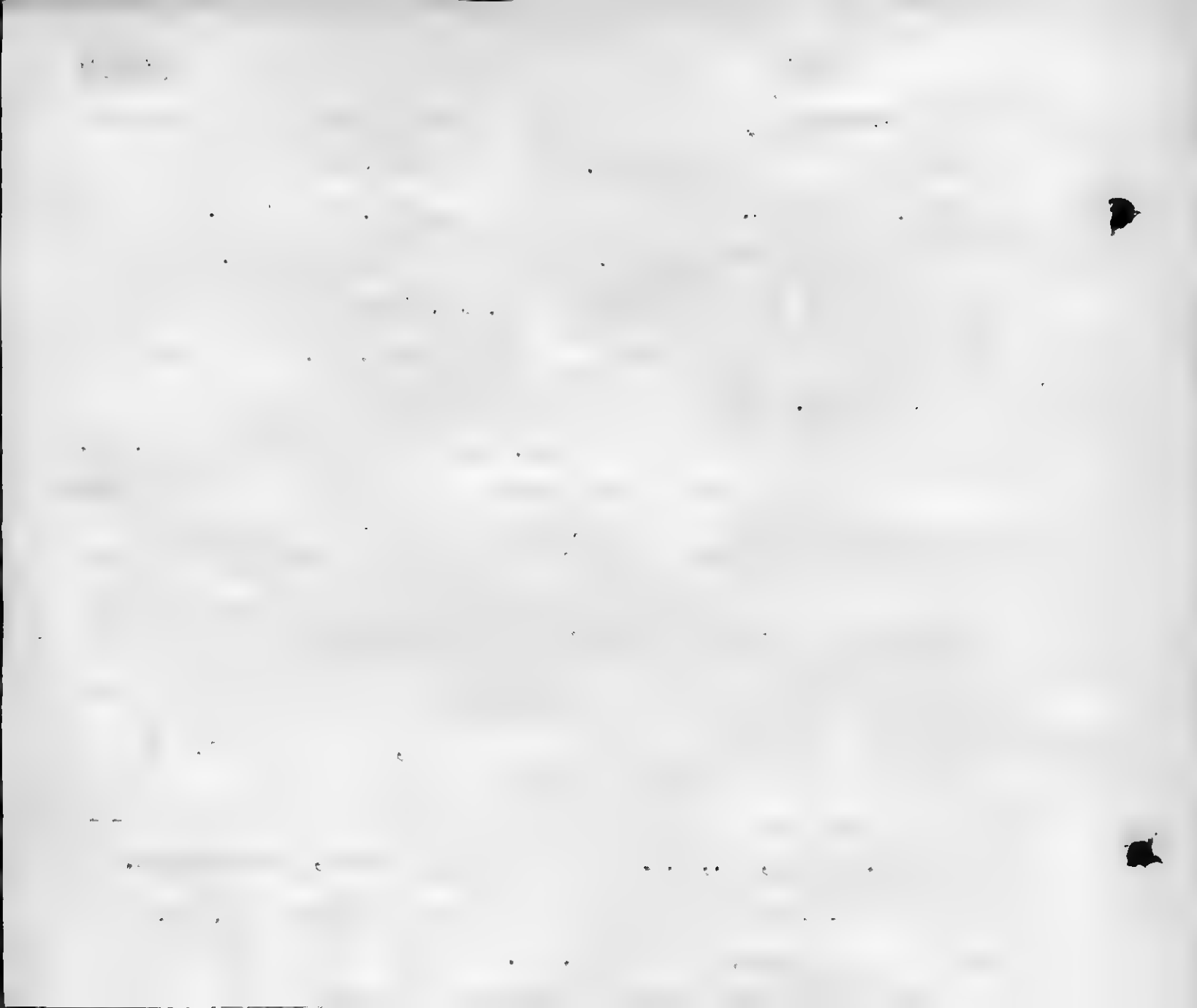
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b 63 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 Vine		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport d. STREET ADDRESS 319 Vine e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Nicolo Last 4. DATE OF DEATH Month January Day 2 Year 1961		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Jan. 17, 1877 9. AGE (In years last birthday) 83 yrs IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0 IF UNDER 24 HRS: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aden Duckworth		14. MOTHER'S MAIDEN NAME Dorcas E. Wilt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Bruce Nicolo-Westernport, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO atherosclerosis heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 days 25 yrs 31 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 1960 to Jan 2, 1961 , that (I) (we) last saw the deceased alive on 1-1-1961 , and that death occurred at 5:14 M. from the causes and on the date stated above			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED 1-3-61	
22c. PHYSICIAN'S NAME (Type) William W. Lesh		22d. ADDRESS Westernport, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/61	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR JAN 4 '61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 59 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 219 W. Offutt St.												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 219 W. Offutt St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
3. NAME OF DECEASED (Type or print) Millard Russell E. Owens						4. DATE OF DEATH Jan. 31 19 61						5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Feb. 12, 1901 9. AGE (In years last birthday) 59 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.																																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper												10b. KIND OF BUSINESS OR INDUSTRY Railroad												11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.												12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Oliver P. Owens												14. MOTHER'S MAIDEN NAME Jennie Troutman												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Mrs. Millard Owens, Cumberland, Md. Address																							
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Heart disease, with cardiomegaly, recent myocardial infarction (Aug 1960) DUE TO (c) Diabetes Mellitus; possible cancer (could not be diagnosed)												INTERVAL BETWEEN ONSET AND DEATH 2 months 3 years (?)																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; possible cancer (could not be diagnosed)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
20a. TIME OF INJURY Hour 19 e.m. p.m. 20b. INJURY OCCURRED White <input checked="" type="checkbox"/> Not White <input type="checkbox"/> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)												21. I certify that (I) (this hospital) attended the deceased from September 2, 1960 to January 31, 1961 that (I) (we) last saw the deceased alive on January 26th 19 61 , and that death occurred at 7 p.m. from the causes and on the date stated above.																																			
22a. SIGNATURE Wyand F. Doerner, Jr., M.D.												22b. DATE SIGNED 2-1-61																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 2-3-1961												23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park 23d. LOCATION (City, town or county) (State) Cumberland, Md.																																			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.												25a. REC'D BY REGISTRAR FEB 6 '61 25b. REGISTRAR'S SIGNATURE Arthur L. Thomas																																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
054
CERTIFICATE OF DEATH

00053

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport			
c. LENGTH OF STAY IN 1b 1 Yr.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 214 Hammond				d. STREET ADDRESS 214 Hammond			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Jesse Potter				4. DATE OF DEATH Month Jan Day 14 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1890	
				9. AGE (In years lost birthday) 71 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil engineer				10b. KIND OF BUSINESS OR INDUSTRY Contracting Co.		11. BIRTHPLACE (State or foreign country) Littleton, Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John S. Potter				14. MOTHER'S MAIDEN NAME Adelaide Marshall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1 023-057456		17. INFORMANT John S. Potter-Westernport, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Pruritus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure. (c) Arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension + Cerebral Atrophy							
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept 1959 to Jan 1961 , that (I) (we) last saw the deceased alive on 1/4/61 19 61 , and that death occurred at 5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE William W. Lesh				22b. DATE SIGNED 1/16/61			
22c. PHYSICIAN'S NAME (Type) William W. Lesh				22d. ADDRESS Main St. Westernport, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 1/16/61		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory-Washington, D.C.		23d. LOCATION (City, town, or county) (State) Concord, Mass	
24. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal				25a. REC'D BY REGISTRAR 17 '61		25b. REGISTRAR'S SIGNATURE C. L. G. Kneass	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00054

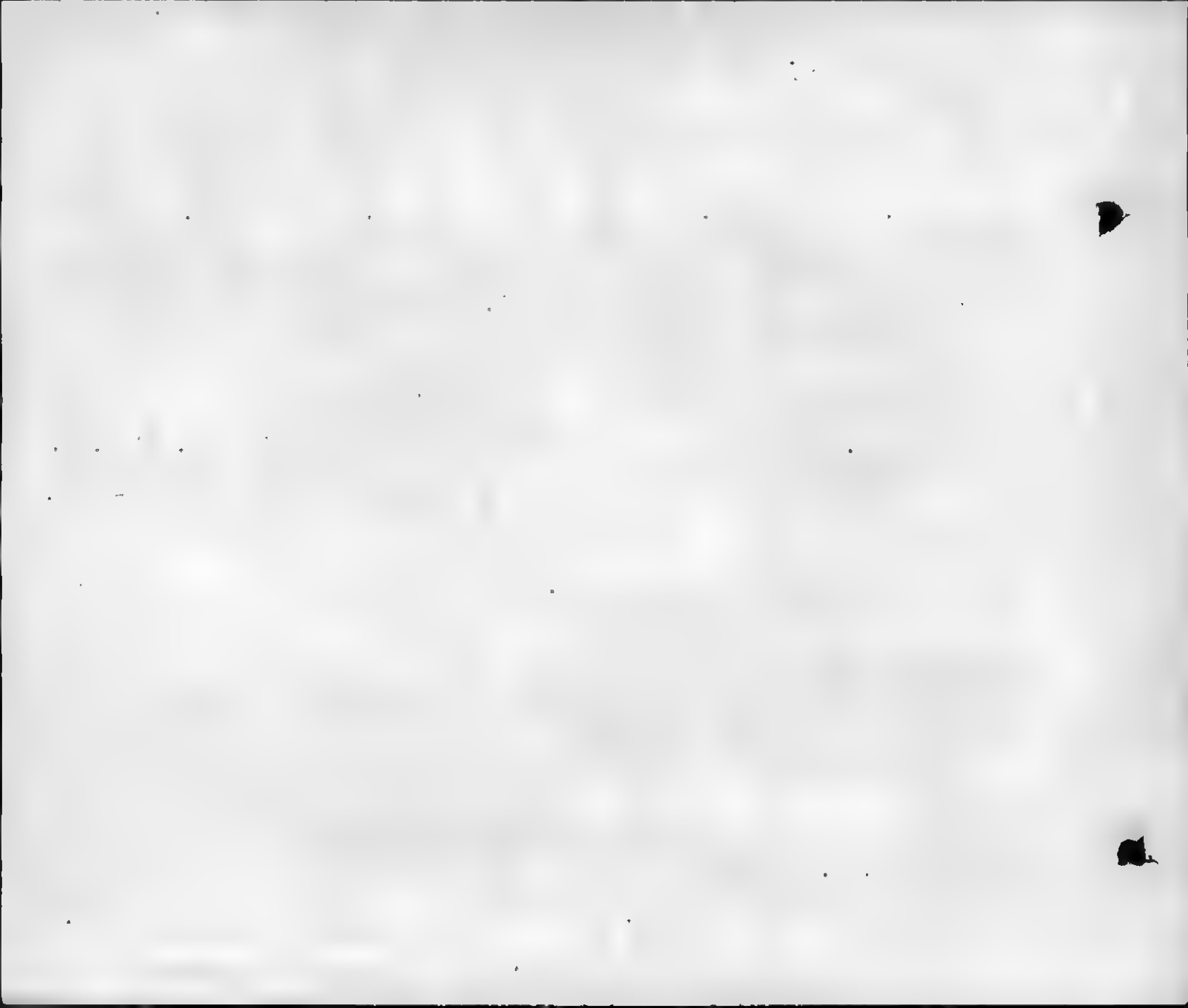
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>142 E. College Ave.</u>				d. STREET ADDRESS <u>142 E. College Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Lindley Rank</u>				4. DATE OF DEATH Month Day Year <u>January 16th, 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
8. DATE OF BIRTH <u>Oct. 22nd, 1895</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Journalist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Journalistic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Henry Rank</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Dando</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.1</u>		16. SOCIAL SECURITY NO. <u>W.W.1</u>		17. INFORMANT <u>Miss Sarah Dando, 97 Hill St., F'bg. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Congestion and Edema, Marked</u> DUE TO <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div style="width: 50%;"> (b) <u>Aortic Stenosis, Myocardial Hypertrophy, Marked</u> <u>Years</u> DUE TO (c) <u>Rheumatic valvulitis with calcification</u> <u>Years</u> </div> </div> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 Hrs.</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>W. O. McLane</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W. O. McLane,</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Jan 19 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>			
22d. LOCATION (City, town, or county) <u>Frostburg,</u>		(State) <u>Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Frostburg, Md.</u>			
24a. REC'D BY REGISTRAR <u>Jan 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in duplicate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.



CERTIFICATE OF DEATH

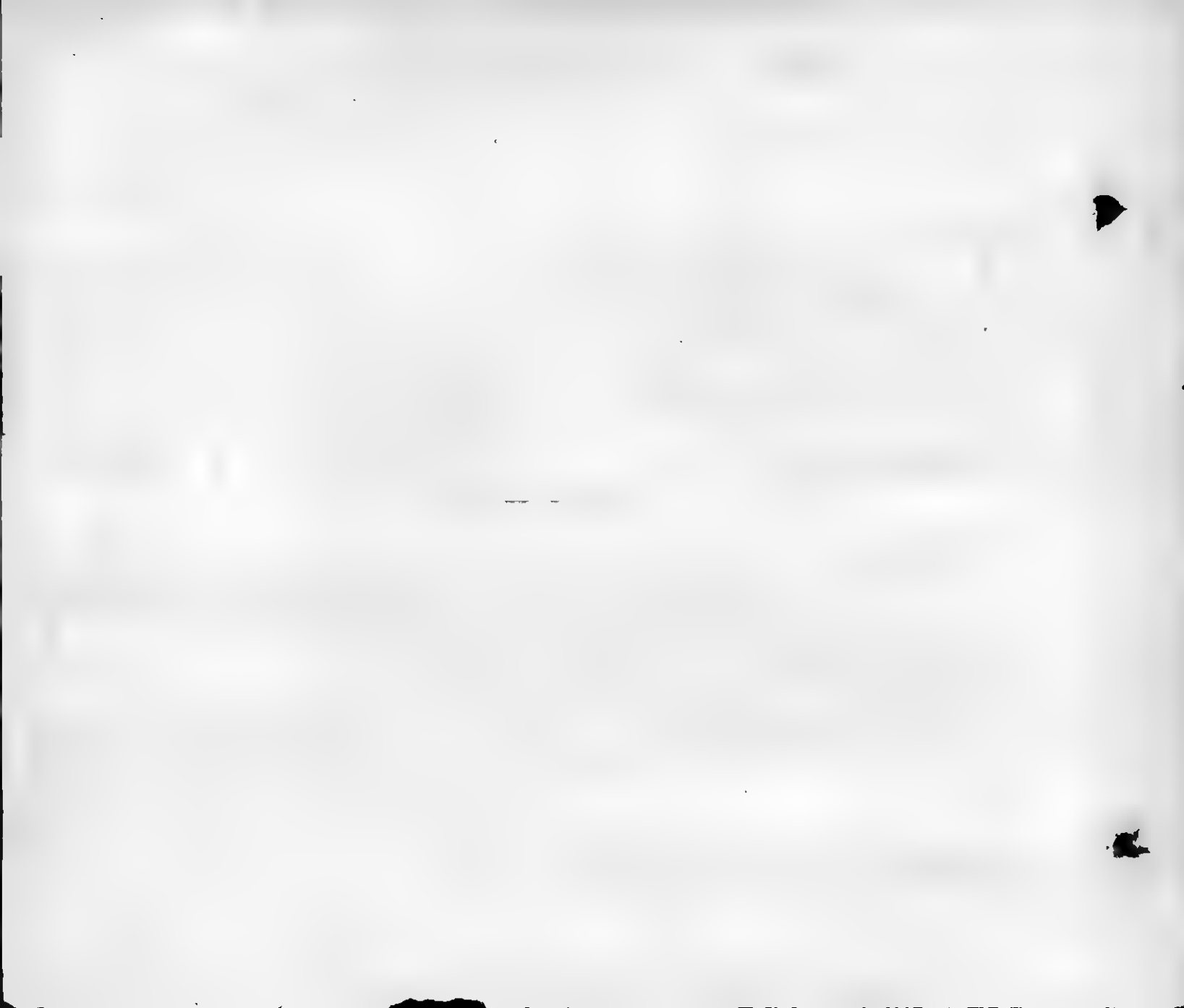
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>109 Offutt St.</i>		d. STREET ADDRESS <i>109 Offutt St.</i>	
3. NAME OF DECEASED (Type or print) <i>Eugenia H Rankin</i>		4. DATE OF DEATH <i>Jan. 4 1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 18, 1886</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. FATHER'S NAME <i>William Koontz</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Kerner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>None</i>	17. INFORMANT <i>Mrs Helen Rawlings</i> Address <i>Cumb. Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 21, 1960</i> to <i>Jan. 4, 1961</i> , that I last saw the deceased alive on <i>Jan. 21, 1961</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clayton J. Barrett</i>		ADDRESS (Street, city or town, state) <i>2366 E. 1st St. Cumberland Md</i> DATE SIGNED <i>1/5/61</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>1/8/61</i>	<i>Rose Hill Cem.</i>	<i>Cumberland Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc.</i> ADDRESS <i>Cumb Md</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 9 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Carroll S. Hume</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



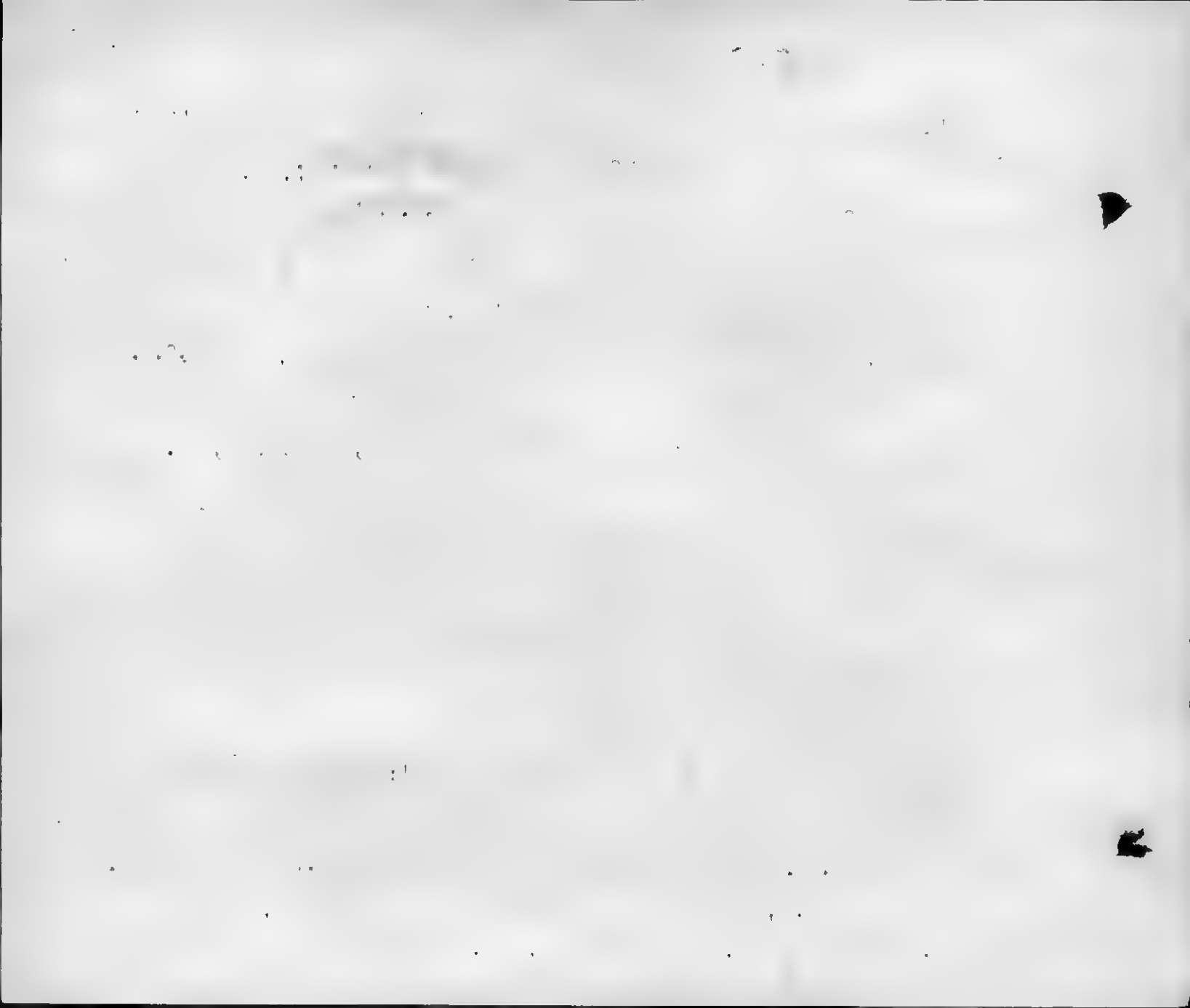
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY (In hrs) 2 1/2 HRS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				e. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Oldtown; Md. Rural d. STREET ADDRESS Sulphur Spring Road				f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GLEN N ROY REDINGER				4. DATE OF DEATH JANUARY 4 1961				5. SEX MALE			
6. COLOR OR RACE WHITE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH APRIL 7, 1896			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer, Retired				10b. KIND OF BUSINESS OR INDUSTRY Saw Mill				9. AGE (In years, last birthday) 64 yrs.			
11. BIRTHPLACE (County & State, or foreign country) Bedford County, Penna., U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS REDINGER			
14. MOTHER'S MAIDEN NAME ZELDA DICKENS				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 217-10-6550			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Disease Hypertensive Cerebral Vascular Disease DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lepus Erythematosa				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)				20c. TIME OF INJURY Month, Day, Year 1961			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. City or town Oldtown, Maryland			
20g. (County)				20h. (State)				21. I certify that (I) (this hospital) attended the deceased from... Feb 20, 1953 to... Nov 29, 1960 , that (I) (we) last saw the deceased alive on... Nov 29, 1960 , and that death occurred at... 1:15 AM from the causes and on the date stated above			
22a. SIGNATURE DR. G. OVERTON HIMMELWRIGHT				22b. DATE SIGNED 1/4/61				22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 7, 1961				23c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery			
23d. LOCATION (City, town or county) Oldtown, Maryland				23e. (State) Md.				24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.			
25a. REC'D BY REGISTRAR JAN 9 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kline				25c. (State)			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

00057

058

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>70 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sylvan Retreat</u>				d. STREET ADDRESS <u>1 348 Baltimore Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Eliza</u> Last <u>Reed</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1961</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/27/81</u>		
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Fezenbaker</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u> </u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE OF <u>592 Chronic Hypertension</u> DUE TO <u>450 General Arteriosclerosis</u> DUE TO <u>592 Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile psychosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan. 12, 1961</u> to <u>Jan. 27, 1961</u> , that I last saw the deceased alive on <u>Jan. 26, 1961</u> , and that death occurred at <u>6:52 M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>James E. McLean</u> M.D.				ADDRESS (Street, city or town, state) <u>49 Greave St. -</u>				
PHYSICIAN'S NAME (Type) <u>James E. McLean, M.D.</u>				DATE SIGNED <u> </u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 30, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>		
						24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>		



may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

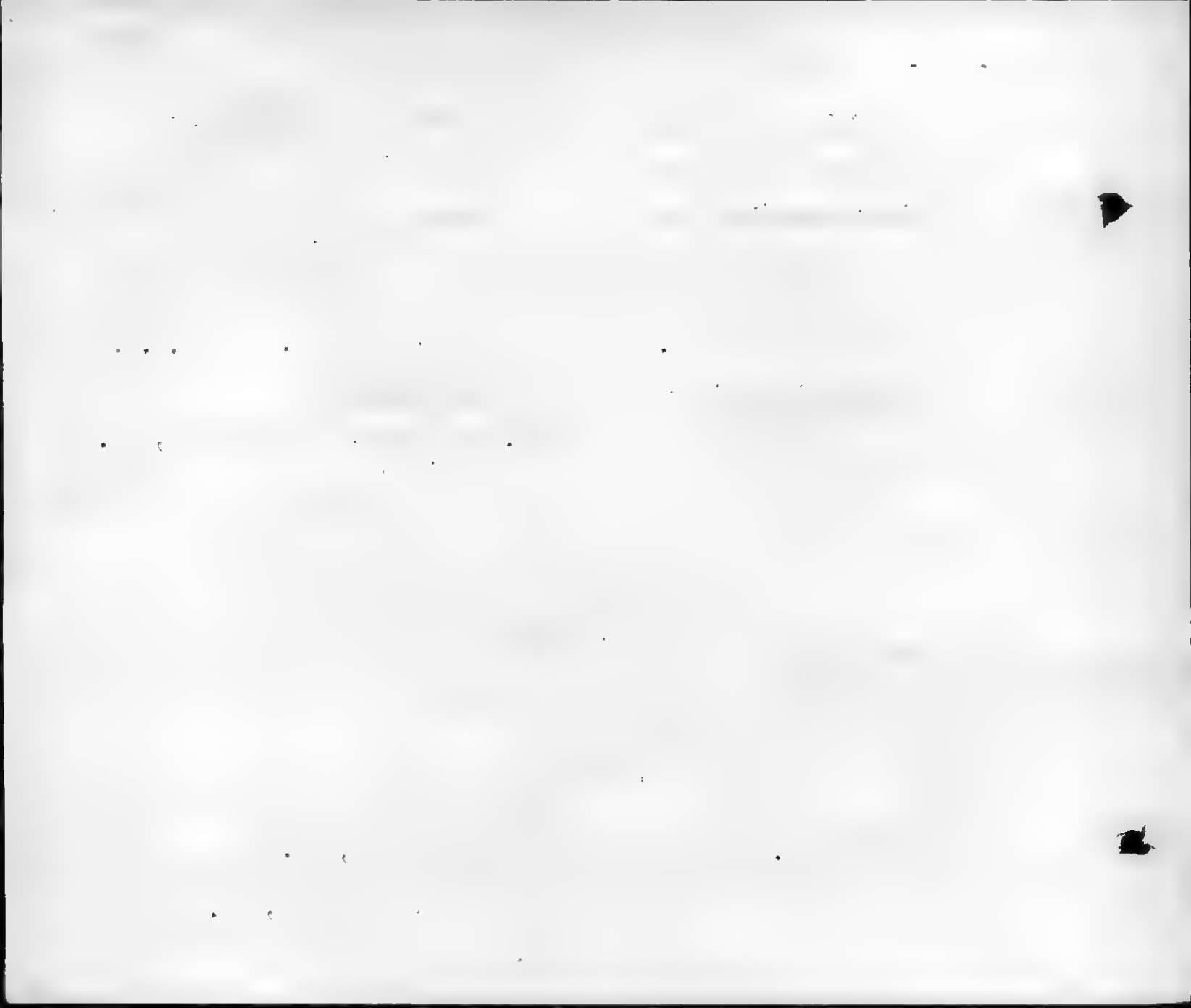
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

059

CERTIFICATE OF DEATH

00058

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland Allegany b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing d. STREET ADDRESS 1 Dudley Street • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) HARRY REIBER		4. DATE OF DEATH 1/13/1961		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/1880		9. AGE (In years last birthday) 80 yrs		10. IF UNDER 1 YEAR Months 1 Days 13 Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Kelly Tire Co.				10b. KIND OF BUSINESS OR INDUSTRY Wellersburg, Pa.				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Reiber				14. MOTHER'S MAIDEN NAME Matilda Long				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)							
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Gene Evans				Address Lonaconing, MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] (DAUGHTER)												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial insufficiency DUE TO (b) Arteriosclerotic cardiovascular disease, 15 yr. DUE TO (c)												1 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): Post operative: subtotal gastric resection												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1961, to Jan 13, 1961, that (I) (we) last saw the deceased alive on Jan 13, 1961, and that death occurred at 11:PM, from the causes and on the date stated above.															
22a. SIGNATURE Alvin J. Walters				22b. DATE SIGNED 1/14/61				22c. PHYSICIAN'S NAME (Type) Alvin J. Walters							
22d. ADDRESS Frostburg, MD.				23a. REC'D BY REGISTRAR DATE JAN 16 '61				23b. REGISTRAR'S SIGNATURE Arthur L. Hanna							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/16/1961		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		23d. LOCATION (City, town, or county) (State) Moscow, MD.							
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONA CONING, MD.				25a. REC'D BY REGISTRAR DATE JAN 16 '61							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

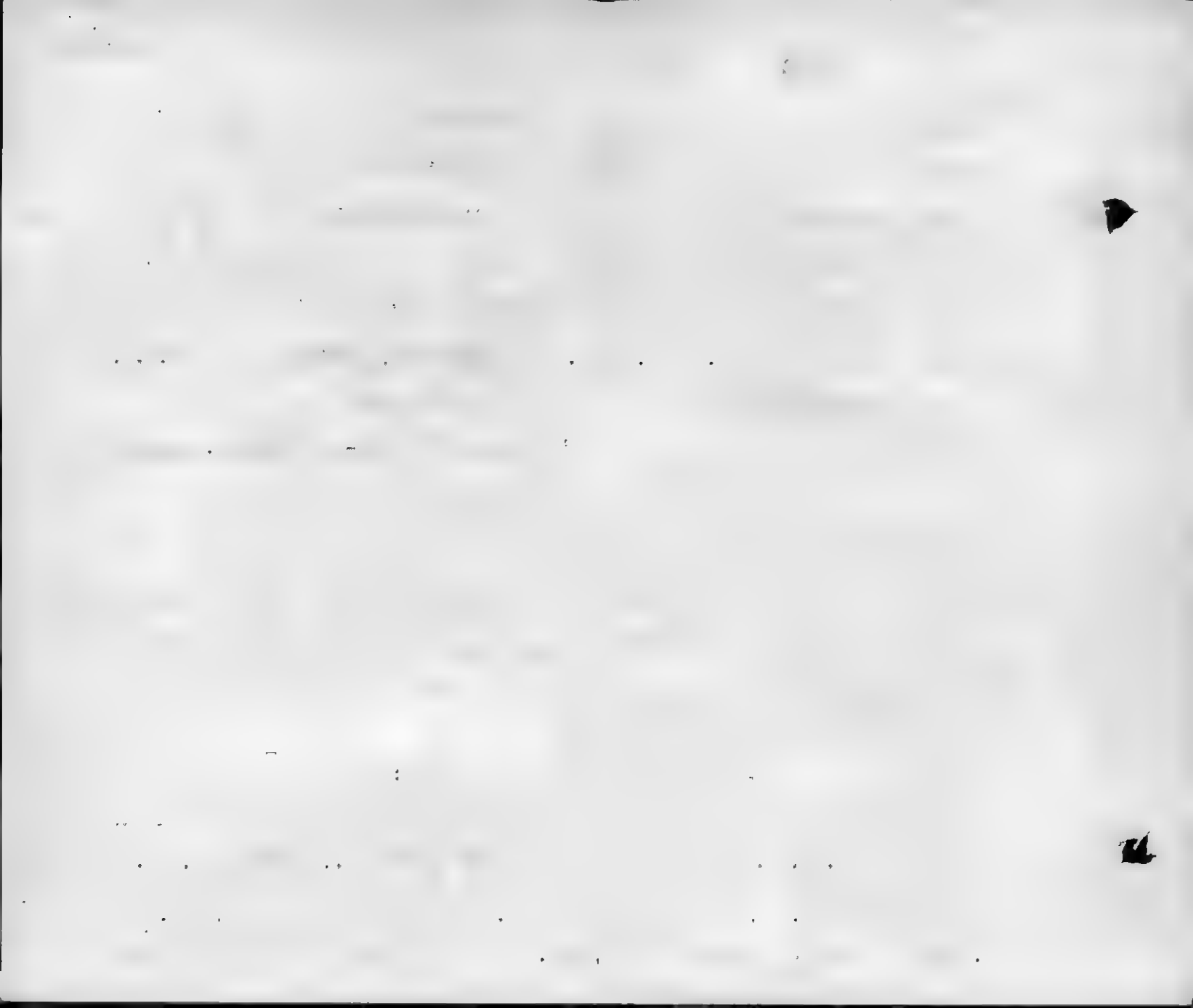
CERTIFICATE OF DEATH

060

00059

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 101 PARK STREET			
3. NAME OF DECEASED (Type or print) RAYMOND		REYNOLDS		4. DATE OF DEATH Month Day Year JANUARY 30 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH MARCH 10, 1893		9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist			
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LAWSON REYNOLDS			
14. MOTHER'S MAIDEN NAME MARY BENNER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW # 1		16. SOCIAL SECURITY NO. WW # 1			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Coronary Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary calculi				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3 - 19... 1950 to 1... 30... 1961 that (I) (we) last saw the deceased alive on 1 - 29... 1961, and that death occurred at 1:30 AM from the causes and on the date stated above.							
22a. SIGNATURE <i>R. W. Ballin</i>		22b. DATE SIGNED 1-30-61		22c. PHYSICIAN'S NAME (Type) DR. R. W. BALLIN			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 1, 1961		23c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park			
23d. LOCATION (City, town or county) Cumberland, Md.		24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR DATE FEB 3 '61			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

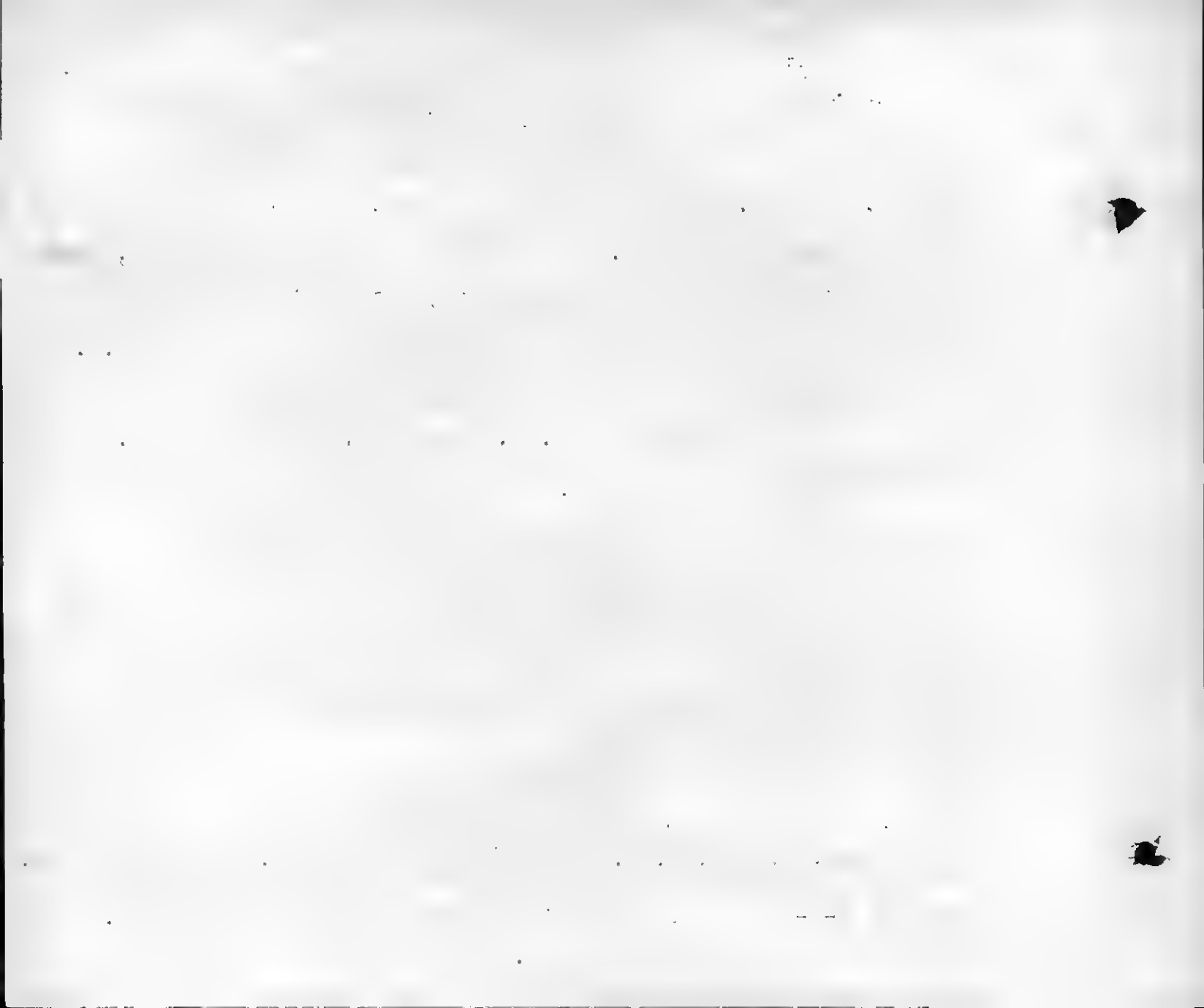
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

061

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C0060

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside of corporate limits, write rural and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 184 W. MAIN ST.				d. STREET ADDRESS 184 W. MAIN ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle C. Last RUFFO				4. DATE OF DEATH Month JANUARY Day 4 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 31, 1915		9. AGE (in years last birthday) 45 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE ENTLER				14. MOTHER'S MAIDEN NAME ELSIE ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service.		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address WM. C. DAVIS, JR., FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma 119.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18]					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/23 19 61 to 1/4 19 61 , that (I) (we) last saw the deceased alive on 12/30 19 61 , and that death occurred at 2:00 A M. from the causes and on the date stated above.							
22a. SIGNATURE Leo H. Ley Jr.		M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/4/61	
22c. PHYSICIAN'S NAME (Type) LEO. H. LEY, M. D.		22d. ADDRESS 456 N. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DAY THEREOF 1-6-61		23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY		23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE JAN 6 '61	
				25b. REG-ISTRAR'S SIGNATURE [Signature]			



may be required by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

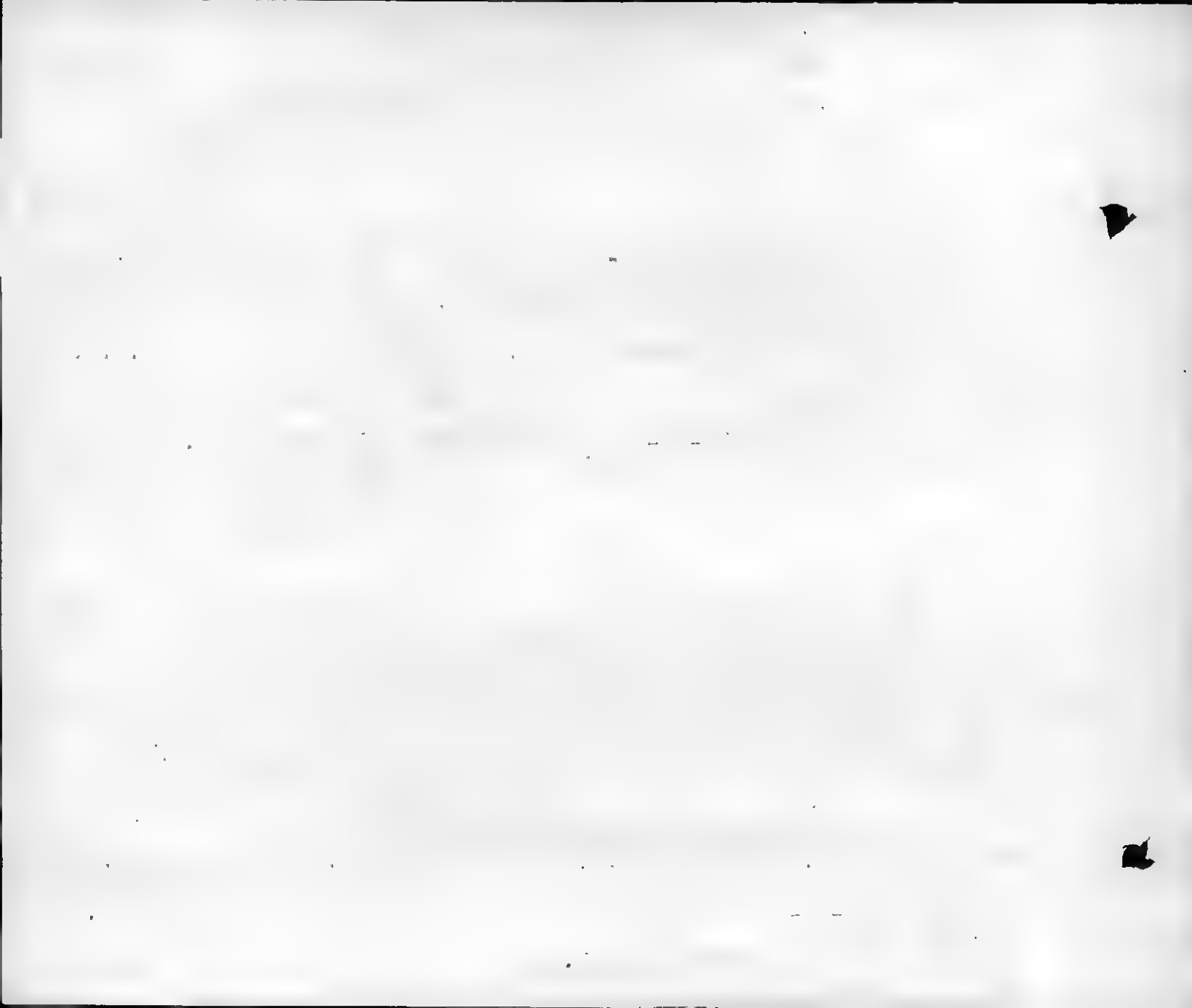
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

062

CERTIFICATE OF DEATH

C0061

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. STREET ADDRESS 11 X - 2	
3. NAME OF DECEASED (Type or print) First RANDOLPH Middle C. Last RUSH		4. DATE OF DEATH Month JANUARY Day 15 Year 1961	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 6, 1909
9 AGE (n years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TIRE BUILDER	
11 BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB RUSH		14. MOTHER'S MAIDEN NAME HANNAH STREID	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 219-03-8348	
17. INFORMANT ANTHONY RUSH, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570-5 DUE TO Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extensive Adhesions DUE TO (c) 3 years		INTERVAL BETWEEN ONSET AND DEATH 2 days - 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Jan 12 , 1961, to Jan 12 , 1961, that (I) (we) last saw the deceased alive on Jan 12 , 1961, and that death occurred at 1:37 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. O. McLane		22b. DATE SIGNED Jan 17 1961	
22c. PHYSICIAN'S NAME (Type) W. O. McLANE, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-18-1961	
23c. NAME OF CEMETERY OR CREMATORY McGAHEYSVILLE CEMETERY		23d. LOCATION (City, town, or county) (State) McGAHEYSVILLE, VA.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Duret		25a. REC'D BY REGISTRAR JAN 17 '61	
ADDRESS FROSTBURG, MD.		25b. REGISTRAR'S SIGNATURE C. L. L. Harris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

063

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CITY, MARYLAND</u>		c. LENGTH OF STAY IN 1b <u>10 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CITY, MARYLAND</u>		d. STREET ADDRESS <u>139 BOND STREET</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HANNIE</u> <u>PEARL</u> <u>SHARRETT</u>				4. DATE OF DEATH Month Day Year <u>JANUARY</u> <u>25</u> <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/1893</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BARRY</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Spencer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212 24-0083</u>		17. INFORMANT <u>CHART</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION, LEFT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>11 hr.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 25, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 27, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u> <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 27 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kins</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. For a burial, cremation, or removal, file pages 1 and 2 with the registrar. For a burial, cremation, or removal, file pages 1 and 2 with the registrar.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

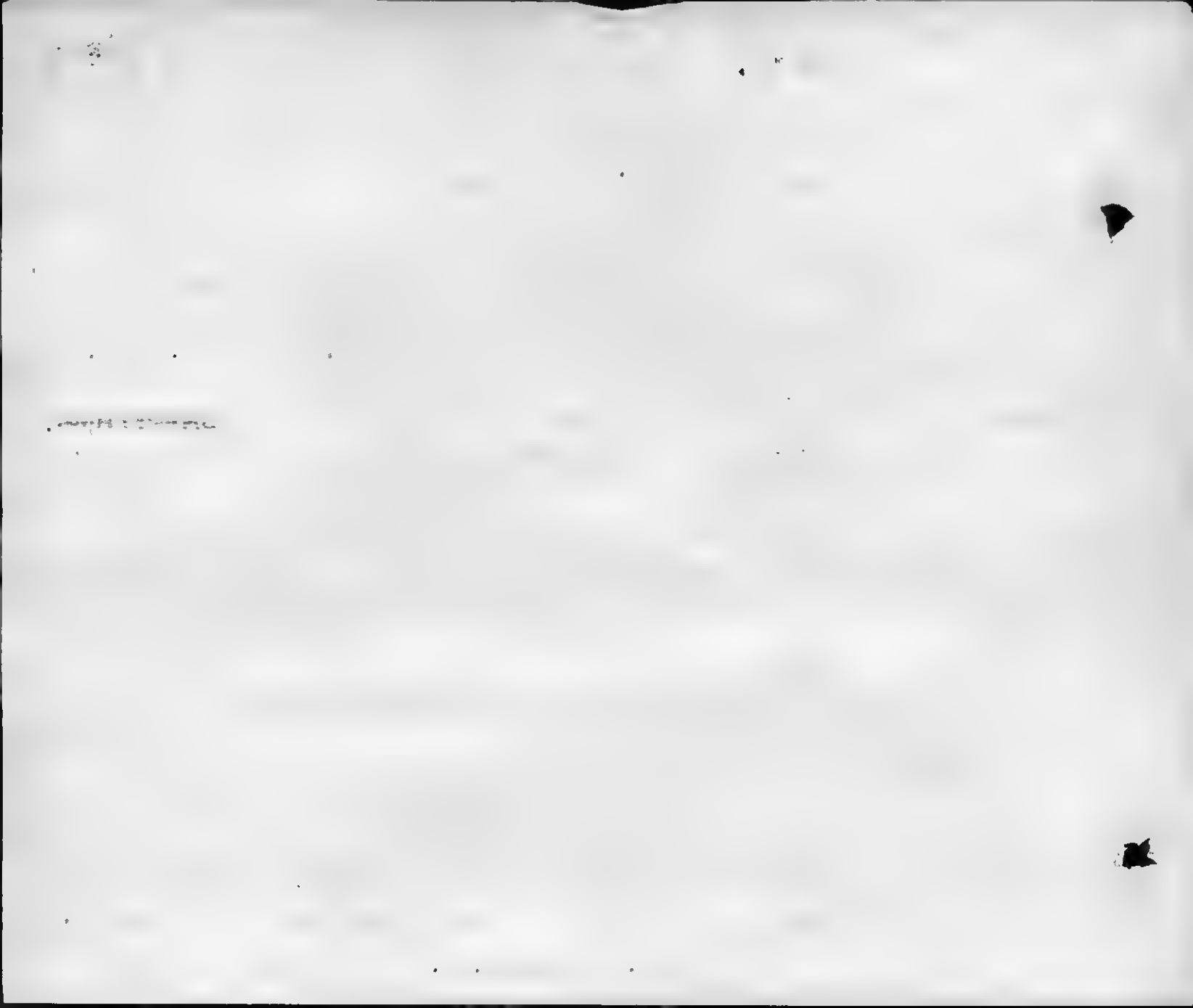
CERTIFICATE OF DEATH

0063

064

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN 1b <u>1wk.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Miners Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>7 Ormond Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALLIE SHEARER</u>		4. DATE OF DEATH <u>1 28 19 61</u>	
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/20/1891</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>28</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frostburg, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Shearer</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Farrady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Ruth Paupe, 227 Henderson Ave., Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per I for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>arterio-sclerotic heart disease</u> (c) <u>Coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAIL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year <u>19 1-28</u> Hour a.m. <u>1-20</u> p.m. <u>1-28</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Frostburg</u> (County) <u>Allegany</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from... 1-20, 1961, to... 1-28, 1961, that (I) (we) last saw the deceased alive on... 1-28, 1961, and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>H.C. Diehl</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>		22b. DATE SIGNED <u>1/30/61</u> 22d. ADDRESS <u>Frostburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/1/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u> 23d. LOCATION (City, town or county) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin H. Winterout</u> 24b. ADDRESS <u>23 E. Main, Frostburg, Md.</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

065

00064

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 7 Hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Route 2,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Carter Last Shryock				4. DATE OF DEATH Month January Day 20th , Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28th, 1889		9. AGE (in years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Roads		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard F. Shryock				14. MOTHER'S MAIDEN NAME Maggie Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 218-24-8303		17. INFORMANT Address Mrs. Nellie D. Shryock, Rt. 2, F'bg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 DUE TO Massive myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Occlusion due to arteriosclerosis DUE TO Heart (c) Heart							INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) X					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 1/27 19 61 , to 1/20 19 61 , that (I) (we) last saw the deceased alive on 1/20 19 61 , and that death occurred at 5:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Martin M. Rothstein M.D.		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/21/61			
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein		22d. ADDRESS 48 Broadway, Frostburg, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-23-61	23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) Frostburg,		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Hurst				25a. REC'D BY REGISTRAR DATE JAN 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	
ADDRESS Frostburg, Md.							



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

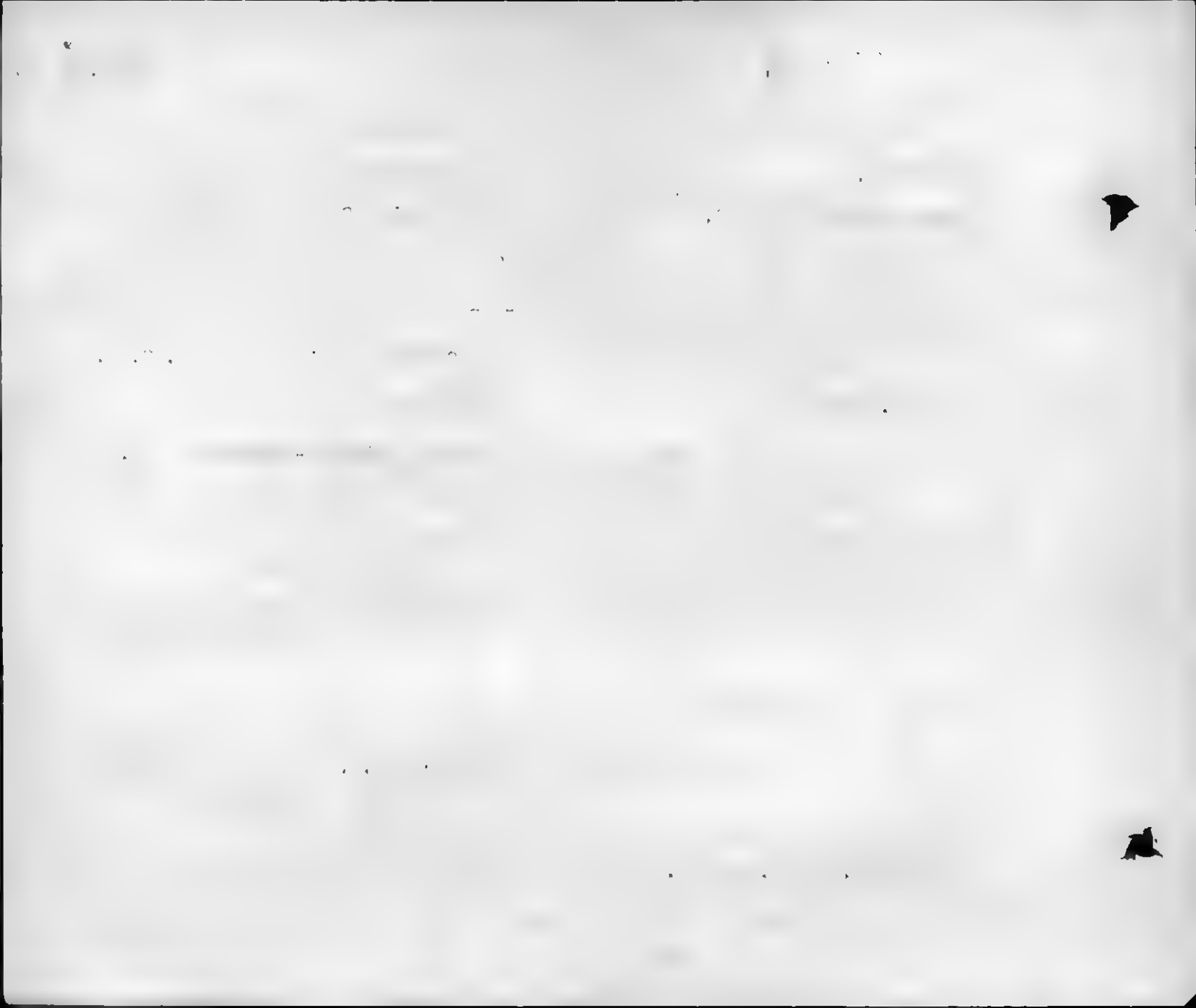
006

00065

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN <u>8 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If outside corporate limits, write RURAL and give nearest town) <u>MEMORIAL HOSPITAL</u> <u>MEMORIAL & WARWICK AVES.</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>79 GREENE STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CORA HELEN SLOAN</u>		4. DATE OF DEATH <u>JANUARY 21 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-1899</u>
9. AGE (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>FROSTBURG, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN H. SLOAN</u>		14. MOTHER'S MAIDEN NAME <u>EMMA HICE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMATION <u>MEMORIAL HOSPITAL-CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>199.2</u> IMMEDIATE CAUSE (e) <u>Gastric Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Metastatic Carcinoma</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>1/13 1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1/13 6:08 P.M.</u> 20f. (City or town) <u>CUMBERLAND</u> (County) <u>MD.</u> (State) <u>MD.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>1/13 1961</u> to <u>1/21 1961</u> that (I) (we) last saw the deceased alive on <u>1/21 1961</u> and that death occurred at <u>1/21 1961</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Leo H. Ley, Jr.</u> 22c. PHYSICIAN'S NAME (Type) <u>DR. LEO H. LEY JR.</u>		22b. DATE SIGNED <u>1/24/61</u> 22d. ADDRESS <u>456 NORTH CENTRE STREET</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial Jan. 24, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 23d. LOCATION (City, town or county) <u>Cumberland, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		25a. REC'D BY REGISTRAR <u>JAN 25 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Robert S. Hance</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00066

Reg. Dist. No.

067

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>318 Md. Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Travis</u> Middle <u>W.</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18, 1892</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harmon Smith</u>				14. MOTHER'S MAIDEN NAME <u>Joann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2405 6336</u> <u>Unknown</u>		17. INFORMANT <u>Wife Alice</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, left; old and recent</u> DUE TO (b) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Star Sclerosis with thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 Hrs.</u> <u>11</u> <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Kitaralic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. B. Skitaralic</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 25, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 28, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file, or to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

068 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LaVale</u>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1077 National Highway</u>				d. STREET ADDRESS <u>1077 National Highway</u>											
3. NAME OF DECEASED (Type or print) First <u>JOSEPH I. DELL</u> Middle <u>SNOW, SR.</u> Last <u>SNOW, SR.</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>28,</u> Year <u>1961</u>											
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 9, 1897</u>		9. AGE (In years last birthday) <u>63</u> yrs.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watch maker & jewelery</u>		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>										
13. FATHER'S NAME <u>Irdell Snow</u>			14. MOTHER'S MAIDEN NAME <u>Mary Jane Vaughn</u>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W War I</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> </td> <td> INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> </td> </tr> <tr> <td rowspan="3"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> DUE TO <u>4-20-1</u> </td> <td></td> </tr> <tr> <td> (b) <u>CORONARY SCLEROSIS</u> </td> <td></td> </tr> <tr> <td> DUE TO (c) </td> <td></td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO <u>4-20-1</u>		(b) <u>CORONARY SCLEROSIS</u>		DUE TO (c)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO <u>4-20-1</u>														
	(b) <u>CORONARY SCLEROSIS</u>														
	DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 											
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED											
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>January 28, 1961</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 31, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hestlam Burial Park</u>											
22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. after</u> ADDRESS <u>Cumberland, Maryland</u>													
24a. REC'D BY REGISTRAR <u>FEB 3 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the State Department of Health, Baltimore, Maryland, for instructions. Give the name of the medical examiner who signed this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

009 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

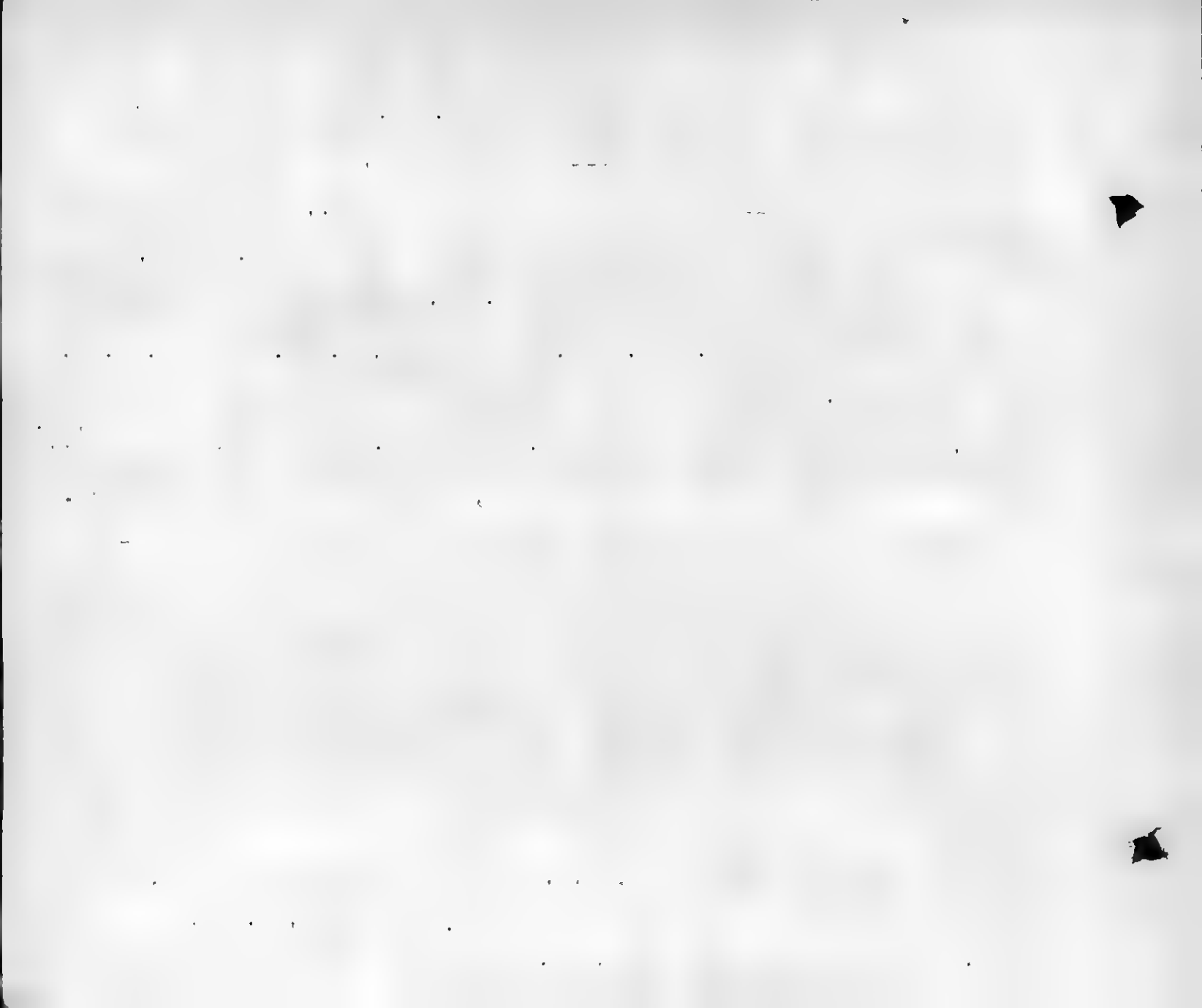
00068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b ***----		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley,			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL--DOA				d. STREET ADDRESS 167 Main St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle OSCAR Last SPANGLER				4. DATE OF DEATH Month Jan. Day 24, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 19, 1909		9. AGE (In years, months, days) 51 yrs.	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) Ridgeley, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Spangler				14. MOTHER'S MAIDEN NAME Elizabeth Everett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rosalie B. Spangler Address Ridgeley, W. Va. 167 Main St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION, RIGHT 420.1 DUE TO Condition: If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY SCLEROSIS WITH THROMBOSIS DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH 24 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitaralic</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitaralic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		January 24, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/61		22c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.				24a. REC'D BY REGISTRAR JAN 30 '61		24b. REGISTRAR'S SIGNATURE <i>William L. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file or for burial, cremation or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

070

00069

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD. c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR IN MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADAMSTOWN, MARYLAND d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NELLIE First W. Middle SPECHT Last		4. DATE OF DEATH JANUARY 13 1961 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 3, 1895 9. AGE (In years lost birthday) 65 yrs IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Hood College & Home for the Aged		11. BIRTHPLACE (State or foreign country) DOUBS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE J. SPECHT				14. MOTHER'S MAIDEN NAME ANNAH E. SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 220-18-2593		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon rectum 153 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) perforation and peritonitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic cardiac vascular disease						INTERVAL BETWEEN ONSET AND DEATH approx 2 yrs approx 2 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1961 , to Jan 13, 1961 , that (I) (we) last saw the deceased alive on Jan 13, 1961 , and that death occurred 3:45 PM from the causes and on the date stated above.							
22a. SIGNATURE Wylie Faw				22b. DATE SIGNED Jan 14, 1961		22c. PHYSICIAN'S NAME (Type) DR. WYLIE FAW	
22d. ADDRESS 122 SOUTH CENTRE, ST., CUMBERLAND, MD.				22e. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland ADDRESS				25a. REC'D BY REGISTRAR JAN 18 '61 DATE		25b. REGISTRAR'S SIGNATURE C. M. & F. Smith	

66

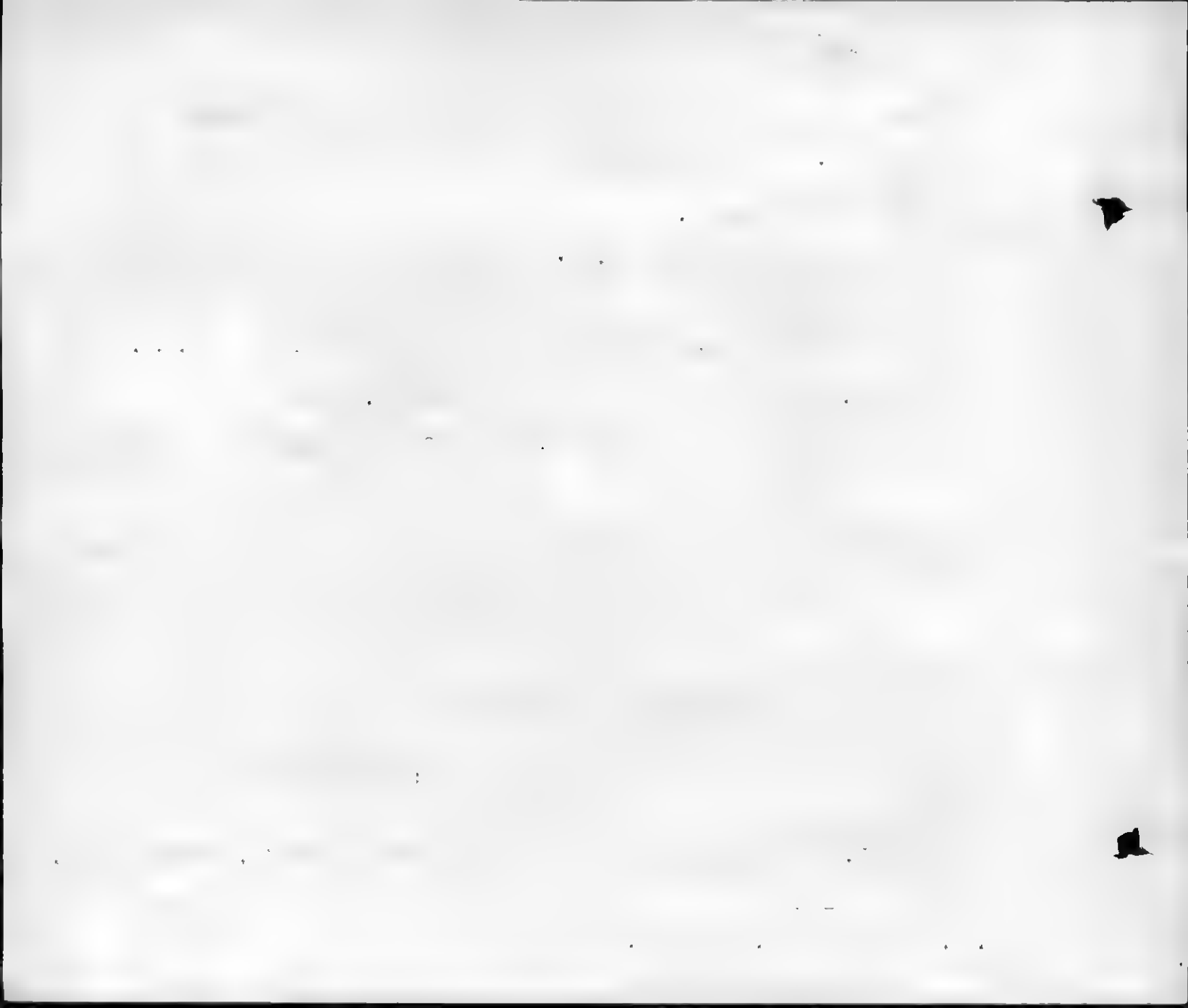
10X-2

1

2

1

1



FOR STATE HEALTH DEPT.

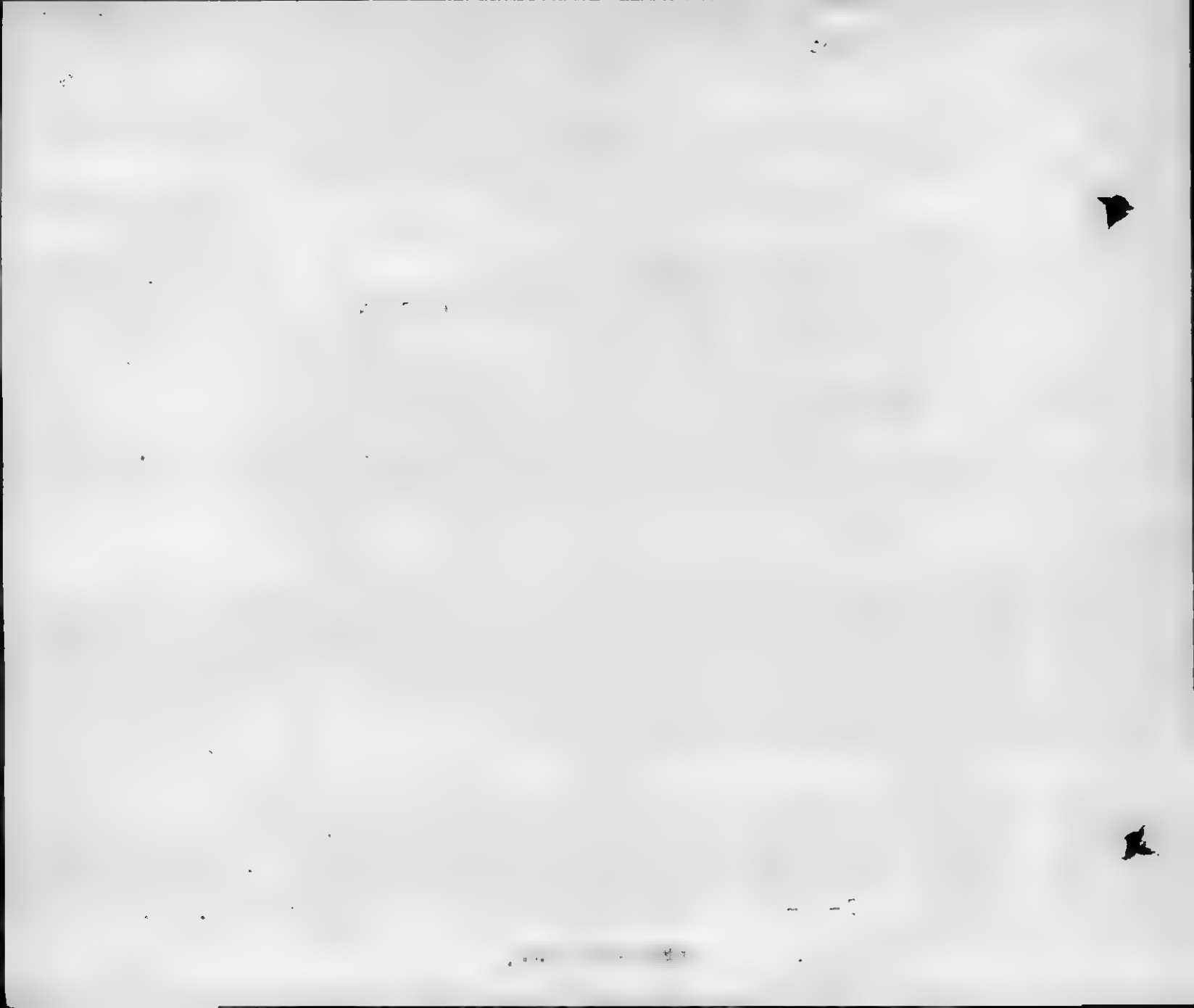
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

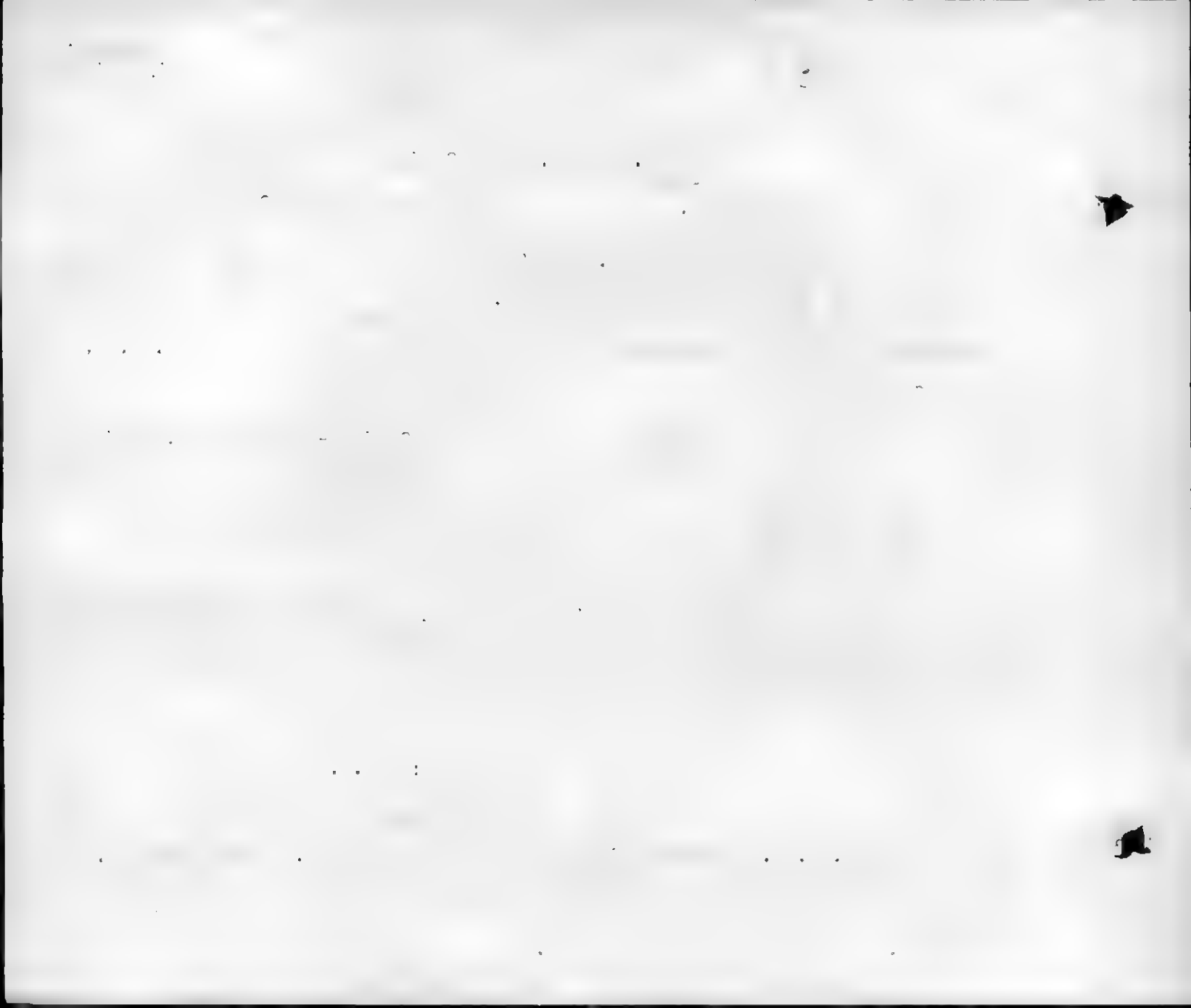
00070

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN c. LENGTH OF STAY IN town 1 yr d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RETA OPAL STURMS				4. DATE OF DEATH Month 1 Day 21 Year 1961		5. SEX FEMALE			
6. COLOR OR RACE WHITE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 31, 1913		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR: Months 1 Days 21 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM HARRIS				14. MOTHER'S MAIDEN NAME NAOMI MURPHY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT WALDON STURMS, MIDLOTHIAN, MD.				Address	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation DUE TO myocardial insufficiency Conditions, if any, which gave rise to immediate cause (b) Sudden (a), stating the underlying cause last. DUE TO 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE W O McLane M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 1-21-61	
EXAMINER'S NAME (Type) W O McLane M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Belington, W. Va. (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-24-61		22c. NAME OF CEMETERY OR CREMATORY BELINGTON CEMETERY		22d. LOCATION (City, town, or country) BELINGTON, W. VA. (State)			
23. FUNERAL DIRECTOR JULIUS RUNNER, ADDRESS BELINGTON, W. VA.				24a. REC'D BY REGISTRAR JAN 25 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 072
 CERTIFICATE OF DEATH
 C0071

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 HR. 45 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AND WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIOLET Middle H. Last STUTLER				4. DATE OF DEATH Month JANUARY Day 12 Year 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 13, 1898	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 62 Hours 62 Min 62		IF UNDER 24 HRS Months 62 Days 62 Hours 62 Min 62			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) INDIANA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JAMES TARR				14. MOTHER'S MAIDEN NAME MARGARET TARR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 20.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Arteriosclerosis (c) Coronary Atherosclerosis INTERVAL BETWEEN ONSET AND DEATH Minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Aug. 12, 1961 to Jan. 12, 1961 , that (I) (we) last saw the deceased alive on Jan. 12, 1961 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE DR. G. O. HIMMELWRIGHT				22b. DATE SIGNED 1/14/61			
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF I-17-61		23c. NAME OF CEMETERY OR CREMATORY Floral Hill Memorial Cem. Clarksburg, W. Va		23d. LOCATION (City or town or county) (State) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
				25b. REGISTRAR'S SIGNATURE Arthur E. Harris			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

073

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00072

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 75 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Gordon Last Taylor				4. DATE OF DEATH Month January Day 28th , Year 1961			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Feb. 25th, 1903	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.		IF UNDER 24 HRS Months 57 Days 57 Hours 57 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Watchmaker		10b. KIND OF BUSINESS OR INDUSTRY Watchmaking		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Taylor				14. MOTHER'S MAIDEN NAME Mary Willison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 2 217-09-6866		17. INFORMANT Mrs. Myra Taylor, 75 Broadway, F'bg. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis liver DUE TO Portal Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 hrs. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Dec 1960 to Jan 28th 1961 , that (I) (we) last saw the deceased alive on Jan 28 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above							
22a. SIGNATURE John B. Davis, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/30/61	
22c. PHYSICIAN'S NAME (Type) John B. Davis				22d. ADDRESS " 2 Broadway, Frostburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-31-61		23c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Burt				ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR DATE FEB 1 '61	
				25b. REGISTRAR'S SIGNATURE William L. Hanna			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

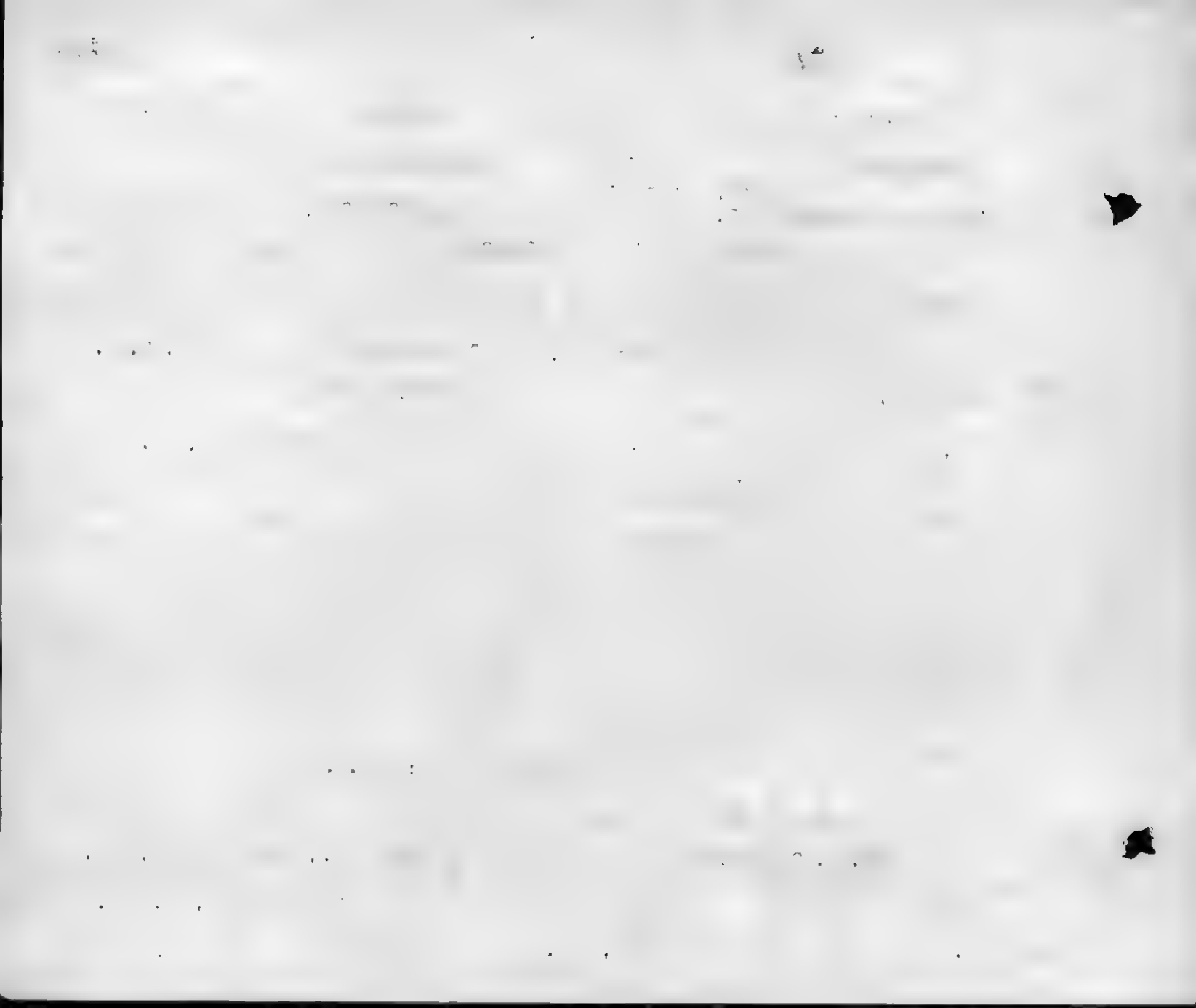
074

CERTIFICATE OF DEATH

00073

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If outside corporate limits, write RURAL and give nearest town) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 14 HARRISON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MILDRED Marie THRASHER		4. DATE OF DEATH Month Day Year JANUARY 10 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 18, 1917
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY C. AUVEL		14. MOTHER'S MAIDEN NAME JACKIE WOTRING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No.		16. SOCIAL SECURITY NO. 214-07-0957	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple sclerosis DUE TO (b) Cerebral infarct with metastases to lung DUE TO (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept. 6, 1960 to June 10, 1961 that (I) (we) last saw the deceased alive on June 10, 1961 , and that death occurred at 9:54 P.M. from the causes and on the date stated above.			
22a. SIGNATURE DR. B. SCHINDLER		22b. DATE SIGNED 1/14/61	
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER		22d. ADDRESS 43 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/13/61	23c. NAME OF CEMETERY OR CREMATORY Shaffertown Cemetery	23d. LOCATION (City, town or county) (State) Shaffertown, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR JAN 16 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
075
CERTIFICATE OF DEATH
C0074

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural		c. LENGTH OF STAY IN 1b 41 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Hazel Viola Trenum		4. DATE OF DEATH Month Jan Day 30 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1904 Aug. 10, 1904
9. AGE (In years last birthday) 56 yrs		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY W.Va.	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Evans		14. MOTHER'S MAIDEN NAME Elizabeth Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO William M. Trenum-R.D. 1 Westernport, Md.	
17 INFORMANT William M. Trenum-R.D. 1 Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive vascular disease DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 yrs.		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 7-25-1960 to 1-30-1961 , that (I) (we) last saw the deceased alive on 12-12-1960 and that death occurred at 6:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Bess Jr. M.D.		22b. DATE SIGNED 1-31-61	
22c. PHYSICIAN'S NAME (Type) Robert W. Bess Jr. M.D.		22d. ADDRESS Piedmont W.Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/61	
23c. NAME OF CEMETERY OR CREMATORY Bloomington		23d. LOCATION (City, town, or county) (State) Bloomington Md.	
24 FUNERAL DIRECTOR'S SIGNATURE E. J. Boal		25a. REC'D BY REGISTRAR Westernport, Md.	
25b. REGISTRAR'S SIGNATURE Charles J. Hines		DATE FEB 3 '61	



076

CERTIFICATE OF DEATH

00075

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1200 Holland Street				d. STREET ADDRESS 1200 Holland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FORRIS		First AUSTIN		Last TRIPLETT		4. DATE OF DEATH Month January Day 10 Year 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 18, 1877	
9. AGE (In years, last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Mins.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Supervisor		11. BIRTHPLACE (State or foreign country) Kerns, W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Randolph Triplett		14. MOTHER'S MAIDEN NAME Sally Kittle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mr. Shawell Triplett, Baltimore, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arteriosclerosis DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month 19 Day 10 Year 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		20g. (County) Allegany		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1/10 to 1/10 , 19 61 , that (I) (we) last saw the deceased alive on 1/10 , 19 61 , and that death occurred at 12:00 PM , from the causes and on the date stated above.		22a. SIGNATURE Leo H. Ley Jr.		22b. PHYSICIAN'S NAME (Type) Leo H. Ley Jr.		22c. DATE SIGNED 1/12/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/61		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		25a. REC'D BY REG STRAR JAN 16 '61		25b. REGISTRAR'S SIGNATURE Charles S. Huns			

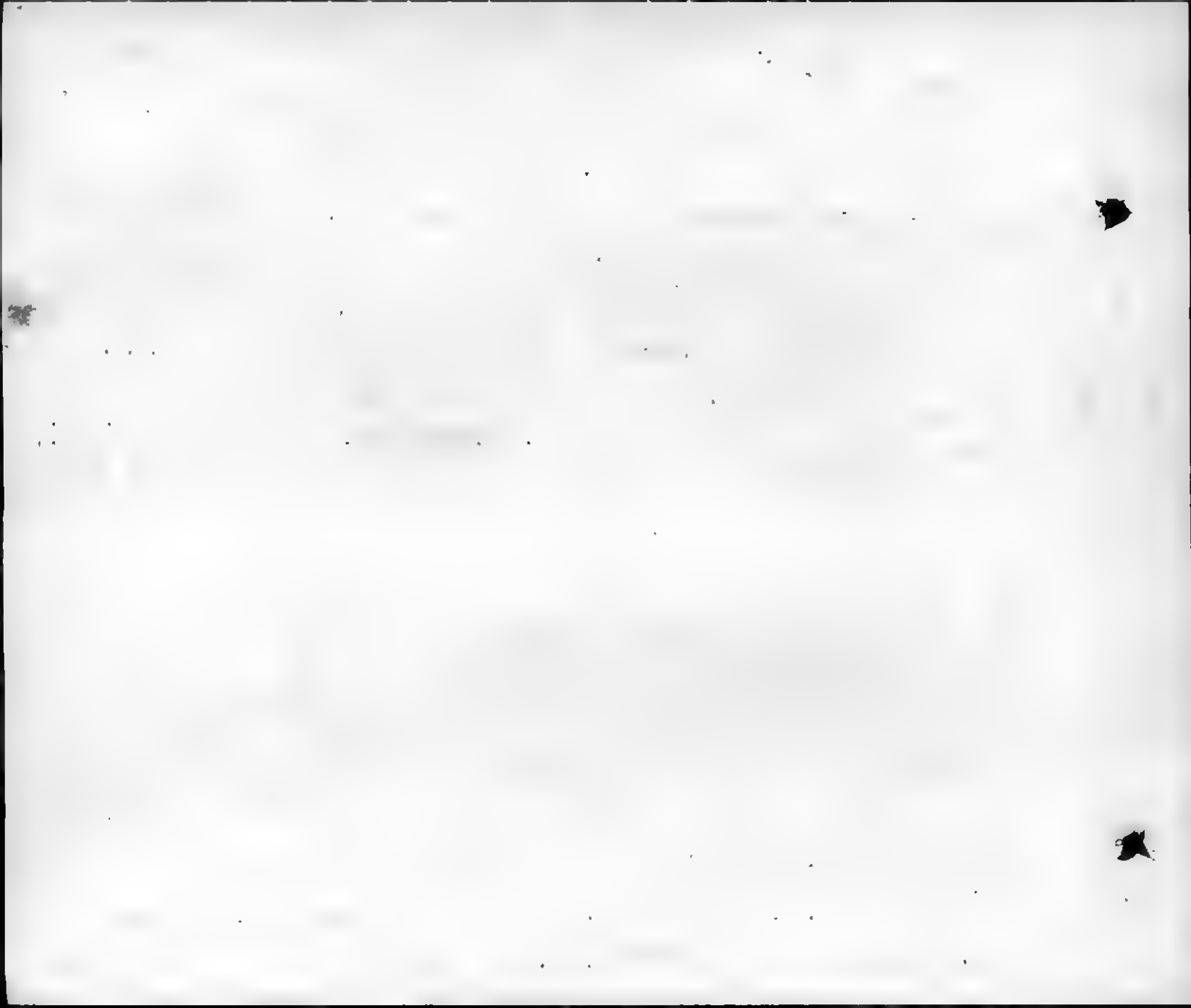


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and completely filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
077
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00076

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 83 Days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thurman Middle Ashford Last Twigg				4. DATE OF DEATH Month January Day 15 Year 1961			
5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1901	
9. AGE (In years last birthday) 59 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George A. Twigg		14. MOTHER'S MAIDEN NAME Lillie Mae Bucy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charlotte M. Twigg		Address Cumb. Md. 447 Goethe St.,		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Lung DUE TO (c) 16mm INTERVAL BETWEEN ONSET AND DEATH 5 mm	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1959 to Jan 15, 1961 , that (I) (we) last saw the deceased alive on Jan 15, 1961 , and that death occurred at M. , from the causes and on the date stated above.							
22a. SIGNATURE Clay Durrett				22b. DATE 1/16/61		22c. PHYSICIAN'S NAME (Type) Dr. Clay Durrett	
22d. ADDRESS 236 Va. Con. Cumberland, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22g. DATE 1/16/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 19, 1961		23c. NAME OF CEMETERY OR CREMATORY Davis Mem. Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS 202 Greene St. Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. REGISTRAR'S SIGNATURE Arthur S. Kraus		25d. REGISTRAR'S SIGNATURE Arthur S. Kraus	



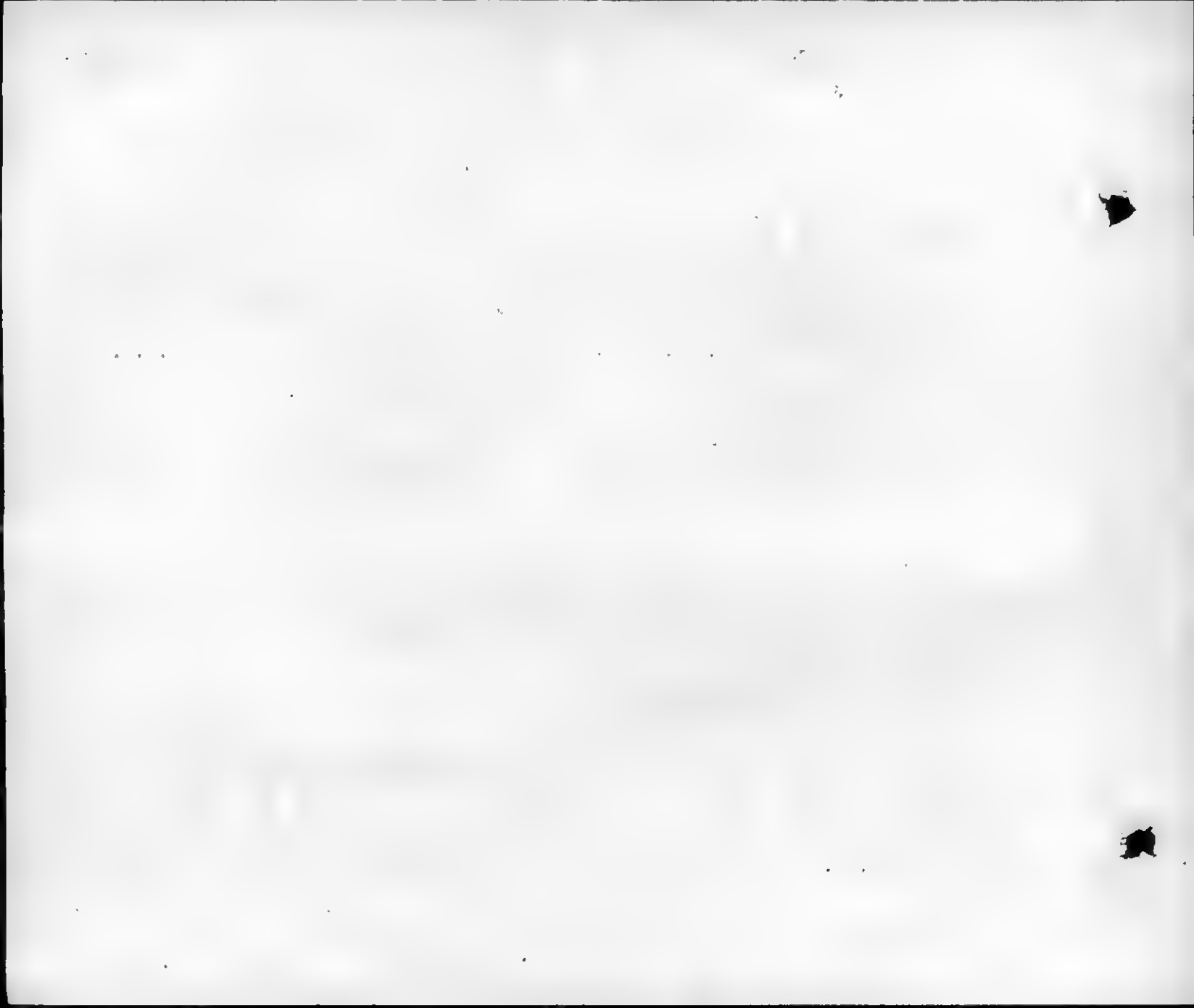
TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

078
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00077

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITRELLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle C Last WALTERS		4. DATE OF DEATH Month 1 Day 17 Year 1961	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 6/9/89	9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Flagman		10b. KIND OF BUSINESS OR INDUSTRY W.Md. R.R.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALBERT WALTERS		14. MOTHER'S MAIDEN NAME SOPHIA PRITTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 712-14-1592		16. SOCIAL SECURITY NO. 712-14-1592	
17. INFORMANT CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334x DUE TO Hemiplegia due to Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 1961 to July 17, 1961 , that (I) (we) last saw the deceased alive on July 16, 1961 and that death occurred at 7:15 AM from the causes and on the date stated above.			
22a. SIGNATURE B. N. Schindler		22b. DATE SIGNED 1/17/61	
22c. PHYSICIAN'S NAME (Type) DR. B. N. SCHINDLER		22d. ADDRESS 43 GREEN STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-19-61	
23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Frost		25a. REC'D BY REGISTRAR Frostburg, Md.	
25b. REGISTRAR'S SIGNATURE Charles E. Thomas		DATE JAN 23 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
079
CERTIFICATE OF DEATH

C0078

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/15/60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Shaw Last White		4. DATE OF DEATH Month January Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/1872
9. AGE (In years last birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Henry Shaw		14. MOTHER'S MAIDEN NAME Agnes Somerville	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allegany County Infirmary records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocardial Degeneration DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary arteriosclerosis DUE TO Chronic Nephritis (c) Senile Deterioration			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/15/60 to 1/18/61 , 19____, that (I) (we) last saw the deceased alive on 1/18/61 @ 10:25 P.M. , and that death occurred at ____ M, from the causes and on the date stated above.			
22a. SIGNATURE James E. McLean		22b. DATE SIGNED 1/19/61	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/21/61	23c. NAME OF CEMETERY OR CREMATORY Memorial Park	23d. LOCATION (City, town, or county) (State) Frostburg Md
24. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal - Westernport.		25a. REC'D BY REGISTRAR DATE JAN 23 '61	
		25b. REGISTRAR'S SIGNATURE Ray E. K...	

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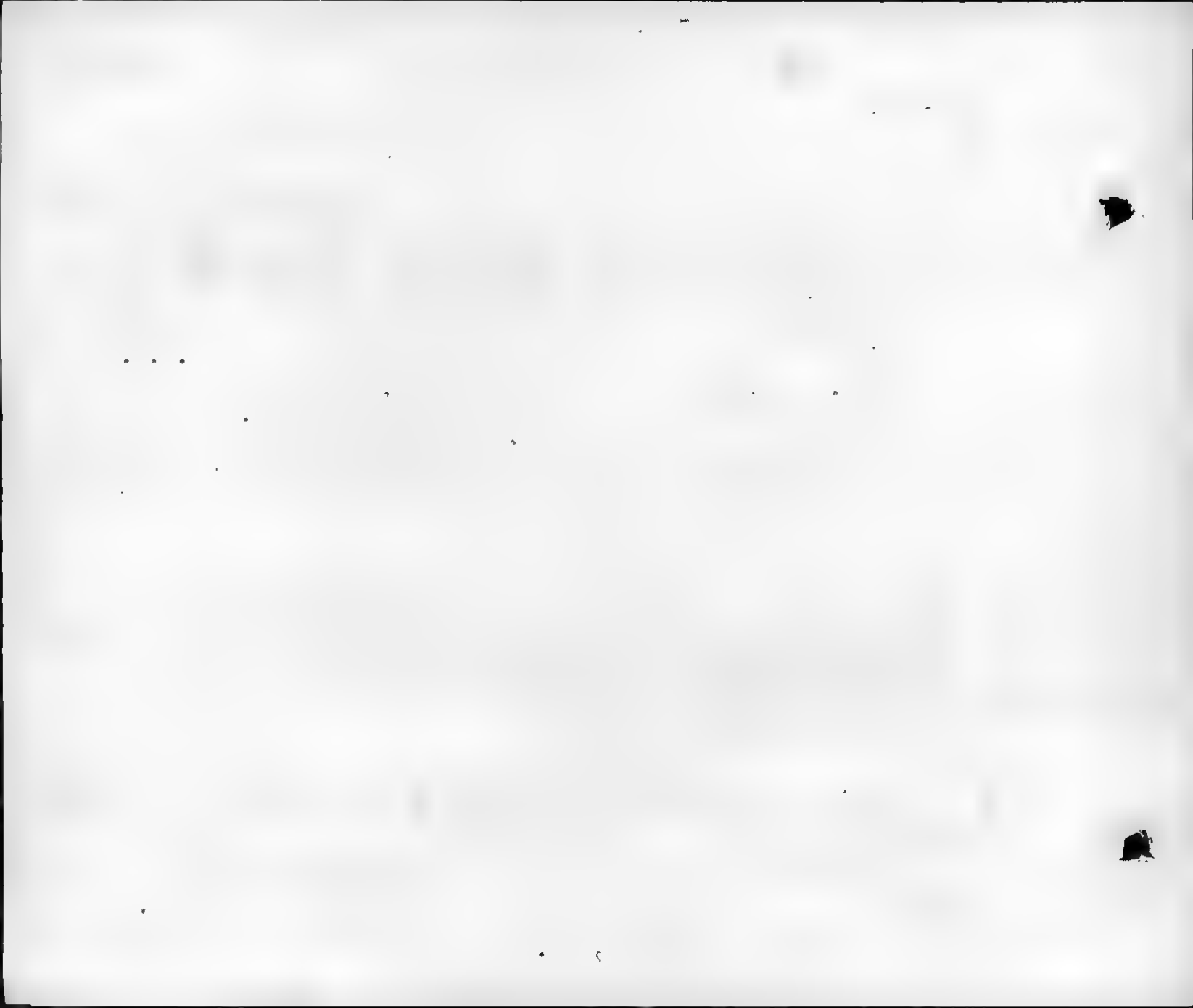
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CERTIFICATE OF DEATH

020 Item 8 1112474 1-15-01 en

00079

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Beechwood Street				d. STREET ADDRESS Beechwood Street			
3. NAME OF DECEASED (Type or print) JAMES		First Middle Last WHITEMAN		4. DATE OF DEATH 1/5/1960		Month Day Year 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/13/1874	
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Whiteman				14. MOTHER'S MAIDEN NAME Jane a. Leatherman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Lonaconing, MD Mr. Simoan Whiteman (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Degeneration Not specified as Rheumatic 42.2.1 DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c) Chronic Myocarditis and Myocardial INTERVAL BETWEEN ONSET AND DEATH 10 Years 10 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Influenza with Acute Bronchitis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 29, 1960 to Jan. 5, 1961 , that (I) (we) last saw the deceased alive on Jan. 2, 1961 , and that death occurred at 4 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Paul R. Wilson				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-6-61	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.				22d. ADDRESS Piedmont, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/8/1960		23c. NAME OF CEMETERY OR CREMATORY Greens Cemetery		23d. LOCATION (City, town, or county) (State) Garret County, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN				ADDRESS LONACONING, MD.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

0080

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 3hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W.Va. b. COUNTY Mineral c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Short Gap, W.Va. d. STREET ADDRESS Rt. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harold R. Yokum		4. DATE OF DEATH I-2-61 Month Day Year 19 61	
5. SEX M.	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1907 yrs. 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buff, Repair Air bags Tire Plants		11. BIRTHPLACE (County & State, or foreign country) Petersburg W.Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Grant Yokum		14. MOTHER'S MAIDEN NAME Grace Hiser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-0896	
17. INFORMANT Hester L. Harr		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 30 minutes			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, W.Va.	20f. (City or town) (County) (State) Cumberland, W.Va.
21. I certify that (I) (this hospital) attended the deceased from 1/2/61 to 1/2/61 , that (I) (X) (b) last saw the deceased alive on 1/2/61 , and that death occurred at 4:15P from the causes and on the date stated above.			
22a. SIGNATURE Richard J. Williams M.D.		22b. DATE 1/2/61	
22c. PHYSICIAN'S NAME (Type) Richard J. Williams		22d. ADDRESS 122 S. Center St. Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF I-5-61	23c. NAME OF CEMETERY OR CREMATORY Maple Hill Cem.	23d. LOCATION (City, town or county) (State) Petersburg, W.Va.
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

page 118

Journal of Management Education

Fig. 29.

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1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

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84. TONE, ST. ILLINOIS

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SI-UT-Case Report # 1017

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
082
CERTIFICATE OF DEATH

00081

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Maryland</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BLANCHE</u> First <u>ARBUS</u> Middle <u>YONKER</u> Last				4. DATE OF DEATH <u>January</u> Month <u>9</u> Day <u>19</u> Year <u>61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/1885</u>			
9. AGE (In years last birthday) <u>75</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Flintstone, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Leroy Chaney (D)</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Christie (D)</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> (c) <u>Coronary insufficiency; extensive myocardial</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <u>Chorea</u> GIVEN IN PART I (a) <u>Uremia</u> <u>Diabetes mellitus</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> or work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21 I certify that (I) (this hospital) attended the deceased from <u>1/6</u> 19 <u>61</u> to <u>1/9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> 19 <u>61</u> and that death occurred at <u>6:55 P</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. S.M. Jacobson, M.D.</u>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Dr. S.M. Jacobson, M.D.</u>				22d. ADDRESS <u>50 Pershing St. City</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/12/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Meth. Cem. Near Cumberland</u>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

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STATE OF OHIO

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